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# Therapeutic communities for treating addictions in Europe

Evidence, current practices and  
future challenges

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for Drugs and Drug Addiction

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Evidence, current practices and  
future challenges

## Authors

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## **| Foreword**

Therapeutic communities first developed in the 1960s, and have continuing relevance in the world of drug treatment today. Fifty years ago, drug use and related phenomena were seen as an increasing problem in Europe, while the means to meet this challenge were very limited. Many drug users, especially heroin addicts, were in need of treatment, and existing health and social care services were ill-equipped for the task.

At this point, therapeutic communities appeared. Often without public funding, based on self-help and a strong feeling of responsibility towards this target group, they quickly played a very important role offering help and support to drug addicts. Some shortcomings of this approach soon became apparent, including a lack of professionalism, problems of scaling up provision, and charismatic leadership that was sometimes lacking control and balance.

Now, 50 years later, the situation of drug use and drug treatment has changed considerably. A variety of different treatment programmes and interventions is available, their effects proven by research findings. Even with these positive developments, for a number of drug users stabilisation is the most positive result that can be achieved. In addition, with new generations of drug users, the choice of substances has changed. The ongoing discussion about which interventions should be used and developed further has intensified recently in a number of countries, taking a more critical look at the status quo of drug treatment.

Given this situation, the EMCDDA found it very relevant and timely to investigate the experience gained with therapeutic communities as an approach to treatment. In addition to looking back to see how these concepts developed in Europe and the role they play in EU Member States today, we wanted to provide policymakers, therapists and experts in the field with an overview of the evidence available for this intervention to allow a critical view of the state of its development.

In this publication we examine the development of therapeutic communities and their availability in Europe, with specific reference to seven countries. We provide an overview of research into the effectiveness of therapeutic communities as a treatment option (some conclusions are positive, others less so) and their impact on wider society, for example in terms of crime reduction. A treatment option can only be measured against recognised standards, and we also look at the guidelines which govern them and consider their implications for management and training needs.

The result of intensive collaboration between authors, peer reviewers and the internal EMCDDA team, this publication will provide readers with new insights, ideas and food for thought in the areas of quality of care and service provision.

**Wolfgang Götz**

Director, EMCDDA



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## **Executive summary**

### **What is a therapeutic community?**

The term 'therapeutic community' (TC) has been linked to a range of treatment traditions and approaches that all share the idea of using the relationships and activities of a purposefully designed social environment or residential treatment setting to promote social and psychological change. TCs offer a drug-free environment in which people with addictive (and other) problems live together in an organised and structured way in order to promote change and make it possible for them to lead a drug-free life in the outside society. The key distinctive characteristic of the TC is the use of the community itself as a fundamental change agent ('community as a method'). There are a number of defining features of the 'community as method' approach, including the use of a range of structured activities in which both staff members and residents are expected to participate and the use of peers as role models who set a positive example and demonstrate how to live according to the TC's philosophy and value system.

### **History of therapeutic communities**

From a historical perspective, the TC for the treatment of addictions was one of the first treatment approaches developed to respond to the emerging heroin problem in many European countries during the 1960s. While European TCs were initially inspired by the North American concept (or hierarchical) TCs, they have developed their own identity: the behaviourist approach of US TCs has been complemented by European educational theories, psychoanalytical thinking, social learning, the involvement of trained professionals (instead of recovered ex-addicts serving as staff members) and a more family-oriented approach. Despite a number of common elements, however, substantial heterogeneity can be observed between European TC programmes.

Over the course of the 1990s, and largely in response to a changing environment with growing interest in harm reduction programmes and new groups of clients in need of drug treatment, TCs in many European countries gradually evolved from long-term, generic treatment programmes to a shorter-term, modified approach. Often this was tailored to respond to the needs of specific groups of drug users, such as drug-using women with children, imprisoned drug users and individuals suffering from psychiatric disorders in addition to their drug problems.

### **Therapeutic community availability and practice**

Although TC programmes for the treatment of addictions exist in most European countries, the use of this approach is not equally distributed. Overall, around 1 200 facilities using TC-type interventions were identified across Europe — with Italy contributing two-thirds of these. While the number of programmes applying the TC approach was low (around five) in many European countries, the TC appeared to be a prevalent treatment modality in most south and some east European countries. Typically, the capacity of facilities offering a TC programme in Europe was between 15 and 25 residents. In most countries the planned length of treatment in TCs ranged between 6 and 12 months.

In recent years, a general European trend towards the limitation of funding for intensive long-term treatment has resulted in the closure of a number of TC programmes and also in a reduction in programme length and the number of client places provided. France is the only country where the TC approach to the treatment of addictions has been re-

established in recent years. In addition, a number of TC programmes have been modified to offer treatment to specific groups, such as drug-using women with children (e.g. Belgium) and drug addicts with concomitant psychiatric disorders (e.g. Belgium, the Czech Republic, Spain, Poland). The inclusion of a pre-TC motivational component and a community-based component for TC graduates transitioning back into the community were identified as new practices in TC programmes in a number of countries (e.g. Belgium). In several countries (e.g. Spain, Poland, the United Kingdom), the establishment of prison-based TCs is a relatively new phenomenon in the TC treatment arena.

### **The current evidence base for therapeutic communities**

Over the past three decades, a body of evidence has been developed in support of the effectiveness of TC treatment for addictions. In order to review the most recent evidence, a literature review was undertaken for this report, drawing on 28 scientific articles reporting 16 randomised controlled studies or quasi-experiments (all conducted in North America) and 21 articles reporting 14 observational studies (conducted in Europe). This review suggests that there is some evidence for the effectiveness of TC treatment in terms of reduced substance use and criminal activity, at least in the USA. A small number of studies also showed positive effects on employment, social functioning and general mental health.

Across the controlled studies in the USA, retention in TC treatment varied substantially. Although positive treatment outcomes strongly correlate with treatment completion, TCs are overall less effective than other interventions with respect to treatment retention. The available evidence suggests that there is an added value for modified — that is shorter or less intensive — TC interventions, when compared with the traditional long-term TC treatment programmes. Clients retained in TC treatment achieved gains in terms of reduced drug use and abstinence and experienced longer periods of drug-free functioning post treatment than those given 'treatment as usual', no treatment or 'modified' TCs.

TC outcome research in Europe is limited to observational studies, and any conclusions are necessarily tentative because of a range of methodological limitations. Generally, however, these studies report positive treatment outcomes, associated with longer retention in treatment and treatment completion, and almost all observational studies report that TC residents show reductions in drug use and arrests and improved quality of life (social and health domains).

One general conclusion that may be drawn from the US and European review is that people in TCs in prison had lower reincarceration rates 12 months after release than prisoners receiving no treatment or assigned to alternative services. In addition, reductions were identified in measures of re-arrest, reoffending and time to reincarceration which were substantially greater than changes in criminal activity achieved by control groups.

### **Service standards**

The development and implementation of evidence-based clinical guidelines and service standards can play an important role in the quality assurance and improvement processes in TCs. However, the establishment of appropriate standards for this complex and ever-changing therapeutic approach remains a challenge. Standards for TCs may need to be less operational than for medically based treatment approaches (e.g. opioid substitution treatment) and need to reflect the daily living and learning circumstances of residents in TCs.

Initial and in-service staff training and regular supervision help to ensure the implementation of service standards where these are available. However, not all European TCs have access to national quality control mechanisms, and opportunities need to be taken to develop cooperation and networking between TCs across Europe — to enhance both knowledge sharing and the transfer of best practice.

### **| Future challenges for therapeutic communities**

In recent years, the TC 'community as method' has been extended to respond to the needs of a number of specific populations, and the future of the TC may depend on successful targeting of areas where they can have a positive impact at an adequate cost. A growing emphasis on expenditure containment is likely to contribute to further reductions in the planned duration of TC treatment episodes. In addition, we are likely to see the role of informal volunteers and self-help elements increasing at the expense of 'professional' staff members akin to North American TC programmes. The way the quantity and, more importantly, the quality of the TC interventions are negotiated is likely to be the main factor determining their future role in addiction treatment.



## **Introduction**

The therapeutic community (TC) is one of the longest standing modalities for the treatment of drug addiction — dating back to 1958, when Synanon, a community of ex-addicts, was founded in Santa Monica (California, USA). The Synanon model quickly spread across the USA, giving rise to the first ‘concept’ TC programmes (e.g. Daytop Village, Phoenix House, Odyssey House) (Goethals et al., 2011). These drug-free, peer-led environments adopted Synanon’s hierarchical structure and therapeutic techniques and set a three-stage treatment model (detoxification, treatment, reintegration), applied by many residential abstinence-oriented treatment programmes since.

A ‘drug-free’ or ‘concept’ TC, later called TC for addictions (De Leon and Ziegenfuss, 1986), has been defined as ‘a drug-free environment in which people with addictive problems live together in an organised and structured way to promote change towards a drug-free life in the outside society’ (Broekaert et al., 1993, p. 55). Not all residential treatment programmes are TCs and not all TCs are organised and delivered in a residential setting (Broekaert et al., 1999). Moreover, not all programmes self-identified as TC programmes employ the same theory, model or method.

The establishment of drug-free TCs in Europe represented the main treatment response to the emerging heroin problems in the 1960s and the early 1970s. From the beginning, the original American TC model was adapted to European culture, integrating the tradition of milieu therapy and elements of a number of psychotherapeutic schools (Broekaert, 2006a). Between 1968 and 1983, TCs were established across Europe (including Belgium, Germany, Greece, Spain, Italy, the Netherlands, Sweden, Switzerland and the United Kingdom). Following the fall of the Iron Curtain in the late 1980s, TCs were established in a number of former communist countries. However, the growing size of the heroin problem, and the advent in the 1980s of the human immunodeficiency virus (HIV) epidemic, prompted the introduction and expansion of other tiers of drug treatment responses, most notably opioid substitution treatment (OST) and harm reduction interventions.

When compared with the 1980s and 1990s, the availability of TC programmes has reduced in Europe. To some extent this may be linked to the relatively high cost of this long-term intensive treatment; however, there are also national and cultural factors at play, as different countries have shaped unique drug treatment provision landscapes and therefore given different degrees of prominence to TC treatment. Chapter 1 of this publication introduces TCs from a historical perspective and provides an overview of their development in Europe and beyond.

This Insights publication integrates the results from an EMCDDA data collection exercise and contributions from key informants from a number of countries (Belgium, the Czech Republic, Spain, France, Poland, Sweden and the United Kingdom) where TC treatment is available and information about it could be accessed. The aim is to provide a Europe-wide overview of treatment provided by TCs, including country-specific features of its history and current role in the wider drug treatment systems, as well as exploring the availability and diversity of such programmes. This is presented in Chapter 2 through an overview of the country-specific features of TC programmes, as well as differences in relation to financing and staffing.

While the latest estimates suggest that around 730 000 problem opioid users are receiving OST in Europe, at least a quarter of a million drug users are receiving other forms of treatment, including drug-free treatment in TCs. Outpatient treatment and rehabilitation is not always a realistic option, particularly for a select group of drug-dependent clients who need the safety, care and structure that TCs can provide. However, while OST is supported by compelling scientific evidence, accumulated over recent decades regarding

the benefits it offers in treating opioid dependence and in improving its associated health and social consequences, the evidence base for the effectiveness of TCs is far less well developed (Smith et al., 2006; Malivert et al., 2012).

In recent years, more is being done to demonstrate clinical effectiveness as funding becomes increasingly linked to evidence. However, applying outcome-based studies to TCs is difficult as the TC intervention is holistic and is not easily broken down into separate observable components that can be measured quantitatively (unlike pharmacological treatments, for example). Thus, applying randomised controlled trial (RCT) methodology to TCs is often a challenge. Chapter 3 provides a comprehensive review of the scientific evidence for TC treatment, both European and international. Findings are presented, grouped by study design and according to country of origin, with a description of the methodologies applied. All the evidence derived from RCTs originates from the USA while European research on TCs has primarily utilised observational methodologies.

Chapter 4 focuses on the use of clinical guidelines and quality assurance frameworks in TC treatment and rehabilitation. These are reviewed with regard to both availability and use in TC treatment delivery at national and international levels.

Finally, changing views on addiction as a chronic disorder and emerging theoretical insights that question prolonged treatment episodes in closed communities are obliging TC practitioners to reflect on the therapeutic objectives and methods of TCs, as well as on how treatment outcome is defined and measured. Examples of the perceived added value of TCs as part of the available responses to drug addiction, and also examples of contemporary challenges in delivering this type of treatment, are highlighted in Chapter 5.



1



## CHAPTER 1

# Therapeutic communities: definition, history and key characteristics

### 1.1. Introduction

Therapeutic communities (TCs) as a treatment modality are found in a variety of populations and settings including addicts, as well as children and young people, prisons, personality disorders and learning disabilities. The term 'therapeutic community' was first used by the British psychiatrist Tom Main (1946) in a description of the so-called 'Northfield Experiments II' from the Second World War, in which soldiers suffering from 'shell shock' and 'war neurosis' were using group processes therapeutically (Harrison and Clarck, 1992). From that moment onwards, the term 'therapeutic community' has been linked to a range of treatment traditions and approaches that share the 'idea of using all the relationships and activities of a residential psychiatric centre to aid the therapeutic task' (Bridger, 1990, p. 60). These treatment traditions are outlined below:

- **TCs for maladjusted children**, around the end of the nineteenth to the beginning of the twentieth century. These communities are associated with the 'new school movement' (the renewal pedagogues such as Célestin Freinet and Edouard Claparède), planned environment therapy (e.g. David Wills) and psychoanalysis (e.g. Anna Freud) (Bridgeland, 1971);
- **democratic TCs**, inspired by the Northfield Experiments and developed by Maxwell Jones for the treatment of neurotic soldiers during and shortly after the Second World War (Jones, 1968; Harrison and Clarck, 1992). Jones strongly emphasised the importance of changing the hospital structure into a more open system facilitating two-way communication, decision-making in consensus and social learning (Vandeveldt et al., 2004);
- **drug-free, concept-based TCs or TCs for addictions**, originating from Synanon, a non-professional community for addicts developed by the American Charles 'Chuck' Dederich in 1958 (Yablonsky, 1967). The central element was the juxtaposition of a hierarchical structure with the Game (later the 'encounter group'), primarily based on confrontation (De Leon, 2000);

- **TCs developed under the impetus of the anti-psychiatry movement in the 1960s**. In anti-psychiatry, TCs were viewed as alternatives to the traditional psychiatric approach to treatment that typically aimed to 'cure' sick patients (Crossley, 1998, p. 878).

The application of the term 'therapeutic community' to denote treatment for different populations in different settings has led to heterogeneity in and a lack of consensus concerning definitions and descriptions of essential elements and principles (De Leon, 2000).

For the democratic TC tradition, an attempt to clarify this heterogeneity was initiated by Clarck (1965) and further elaborated by Kennard (1998) — both of whom marked a notable distinction between what they called the TC 'proper' and the TC approach. In the former, a specific small ward, unit or hospital was designed explicitly to make the social environment the main therapeutic tool (Clarck, 1965, p. 948). In the latter, the community and group methods were not the exclusive means of treatment but were applied to create an atmosphere of respect for the patient's individuality, attention to daily activities and work, responsibility, and personal relationships (Clarck, 1965).

These two origins (TC 'proper' and TC approach) help to explain some of the variety that has developed in the field. First is the difference between the intensive, small, inpatient TC 'proper' and TC 'approaches' to humanising whole hospitals (Clarck, 1965). In US terms, the attempt to humanise whole hospitals, and to utilise the general social environment, has come to be described as 'milieu therapy' (Schimmel, 1997, p. 121).

The general stream of 'concept-based' or 'hierarchical' TCs, developed in the USA during the 1950s, includes the intensive inpatient-type programme, explicitly targeted at the addictions, and organised on an explicitly non-psychodynamic model of closely monitored and highly intrusive social conditioning, designed to get people off drugs and to provide a complete break from their past lifestyle.

Nonetheless, there are a number of general points that encompass the range of TCs. The TC is essentially a living learning situation, which means that residents are totally immersed in the treatment environment, so that all of their daily behaviour and their emotional and physical state can be observed and challenged as appropriate through intensive group experiences. In addition, they are encouraged to experiment with alternative behaviours and corrective emotional experiences. Thus, Roberts defines the TC as 'a consciously-designed social environment and programme within a residential or day unit in which the social and group process is harnessed with therapeutic intent (Roberts, 1997, p. 4). In the TC, the community is the primary therapeutic instrument.' (De Leon, 2000, p. 93).

This publication specifically focuses on concept TCs or TCs for the treatment of addictions, and henceforth the two terms are used interchangeably. TCs for addictions are defined in a subsequent section and the latter part of this chapter focuses on the TC treatment model and its key features. This chapter concludes with a short review of the history and development of TCs in Europe.

## 1.2. Definition

As noted above, a number of definitions for TCs have been put forward in the literature, which clearly reflects work in progress with regard to achieving consensus on what could be termed a TC.

For the purposes of this Insights publication, the following integrative definition of TCs for the treatment of addictions will be used:

'A therapeutic community is a drug-free environment in which people with addictive (and

other) problems live together in an organized and structured way in order to promote change and make possible a drug-free life in the outside society' (Broekaert et al., 1993, p. 55)

'The fundamental distinction of the therapeutic community is that it utilizes "community as method" in addressing the substance abuse and social and psychological problems of the individual' (De Leon, 1997, p. 269)

This definition can be expanded as follows:

'The TC forms a miniature society in which residents, and staff in the role of facilitators, fulfil distinctive roles and adhere to clear rules, all designed to promote the transitional process of the residents. Self-help and mutual help are pillars of the therapeutic process, in which the resident is the protagonist principally responsible for achieving personal growth, realizing a more meaningful and responsible life, and of upholding the welfare of the community. The program is voluntary in that the resident will not be held in the program by force or against his/her will' (Ottenberg et al., 1993, pp. 51–62).

## 1.3. Key features

Central to the above definition and to the TC treatment practice is the concept of 'community as method' or, in other words, the 'purposive use of the peer community to facilitate social and psychological change in individuals' (De Leon, 1997, p. 5). There are, however, a number of other defining features of TCs. Table 1.1

TABLE 1.1  
Key features of therapeutic communities (TCs)

Concept TCs		Democratic TCs	
<b>Self-help</b>	The resident is the protagonist of his own treatment. Other residents can act only as facilitators	<b>Permissiveness</b>	Residents can freely express thoughts and emotions without any negative repercussions
<b>Hierarchy</b>	Daily activities take place in a structured setting where residents act as role models	<b>Democratisation</b>	All staff and residents participate equally in the organisation of the community
<b>Community</b>	Living together in a group and fostering belonging is the main agent for therapeutic change and social learning	<b>Communalism</b>	Face-to-face communication and free interaction to create a feeling of sharing and belonging
<b>Confrontation</b>	Residents present to each other feedback — observations of, and reactions to, behaviours and attitudes that interfere with community rules, value and philosophy and which should be changed	<b>Reality testing</b>	Residents are continually confronted with their own image as perceived by other residents and staff

summarises the key features of both concept (drug-free, hierarchical TCs for the treatment of addiction) and democratic (Maxwell Jones-type) TCs, both of which are included in the TC definition applied to this publication.

Despite the various origins of application of the term 'therapeutic community', there are some commonalities and generic aspects that are quintessential for TCs from the different branches set forth in the introduction. Glaser (1981), for instance, notes that a key feature of both addiction TCs and democratic TCs is that residents, in collaboration with the staff, become active participants in their own therapy and that of other residents and in the general conduct of the entire programme. Others have put forward the hypothesis of a 'generic' model underlying TCs throughout the world (for a review, see Goethals et al., 2011, Chapter 5) or shared perspectives, including the following seven characteristics (Kennard, 1994, cited in Whitwell, 1998, p. 76):

'a group of people living together; intimate, informal relationships; regular and frequent sharing of information between all group members; a shared commitment to the goal of learning from the experience of living and/or working together; a shared commitment to the open examination and resolution of problems, tensions and conflicts within the group; a psychodynamic awareness of individual and group process and a clear set of boundaries concerning time, place and roles'.

Broekaert (2001, p. 29) adds the following core elements 'which cannot be changed in a TC': a striving for integration in the wider community; everybody (both staff and clients) should be open to challenge and confrontation; ex-addicts can be considered as role models; staff should act according to ethical standards; and the duty to review their mission and vision on a regular basis.

#### 1.4. The theory, model and method of the therapeutic community

De Leon (2000) makes a distinction between the theory, model and method of TCs. The theory concerns the TC perspective on how to view the disorder, the person, recovery and right living. The model consists of the generic programme components and the method can be described as 'community as method' (De Leon, 2000).

**Theory:** TCs are characterised by a specific view on how to understand addiction. It is certainly not seen as a disease, but rather as a problem of the 'whole person'. From that point of view, treatment has nothing to do with the 'drug', but rather concentrates on the 'person' him- or herself (De Leon, 1997, p. 9). This point of view is reflected in the TC philosophy — based on early Christian values, the Oxford groups, Alcoholics Anonymous, Synanon and the humanistic psychology — that highlights the belief in the resident's potential and personal growth (Broekaert, 2001). The person is considered as emotionally frail and immature, but with the potential to change positively. In order to stress that people can be educated and do not have to be cured, TCs speak about 'residents' rather than 'patients' (Broekaert, 2001). In a TC, residents are expected to strive towards 'right living' or a positive lifestyle, in accordance with the TC philosophy. Right living includes values such as honesty, responsible concern, dedication, work ethic and the consideration of learning as a main value (De Leon, 2000). Recovery is not used in the traditional medical way (i.e. becoming abstinent), but rather as an indication of a more fundamental change in identity and lifestyle (De Leon, 2000).

**Model:** The essential elements of a generic TC model include aspects such as the community's physical environment, the social organisation, work as therapy and education, TC staff members, peers and their roles in the TC, relationships and programme stages.

A TC programme typically consists of three stages: an induction phase (1–60 days); a phase of primary treatment (2–12 months); and a re-entry phase (13–24 months). In some, but not all, TCs, these phases are further structurally refined into the following stages: crisis intervention, ambulatory induction, reception, induction, treatment and social (re-)integration (Broekaert, 2001). When going through the stages, TC residents gradually gain more responsibilities and privileges. Furthermore, several stages with regard to the residents' internalisation of change can be discerned, evolving from compliance over conformity and commitment towards integration. Eventually, this leads to true identity change (De Leon, 1994, 1995, 2000).

The TC's physical environment, which reflects consistency and predictability, contributes to the residents' change process. The following basic rules ensure an environment of trust and safety in every TC programme: no drugs or alcohol, no violence and no sexual relationships. With regard to the social organisation, the pyramidal structure of hierarchy is important. Work activities are an essential part of TC treatment, and the process of working, which results in

personal growth, is more important than the 'material' results that are realised. The structure is reflected by daily routine and the organisations in service departments (kitchen, administration, laundry), each of which have their own internal hierarchy. Residents move from having little or no responsibility to becoming department heads or even the co-coordinator of the TC.

The TC is organised according to a daily regimen, during which residents and staff members are expected to share meals and attend meetings, such as the community meeting (De Leon, 2000). Every day starts with the community meeting, followed by morning activities, lunch, free time, afternoon activities, dinner, and some free time before going to bed. The primary goal of the community meetings is to strengthen community feeling and cohesion (De Leon, 2000).

Peers play a very important role with regard to the social learning process in TCs (De Leon, 2000). They are considered 'role models' who give the right example by living according to the TC's philosophy and value system. In this respect, Broekaert (2001, p. 37) describes TC treatment as 'an intensified form rebuilding a value system, one that uses old principles of therapeutic education and social learning, and adapts them to the needs of the drug-abusing population'.

Interpersonal relationships, both inside and outside the programme, are used to support the process of change. Residents can learn skills to communicate with and relate to other people in a safe environment. Family work is considered an essential element of TCs and efforts are made to involve family members and prepare clients for meeting their relatives (Broekaert, 2001).

**Method:** Although essentially all activities and interactions contribute to recovery, the 'daily regimen of structured activities, is viewed as methods'. Community as a method is identified as the quintessential element, with the following basic components, among others: a community environment, with a range of community activities and peers as role models; a structured day, in a phase format, with work as therapy and education; peer encounter groups; and a planned duration of time (De Leon, 1994, pp. 24–27). During the day, seminars, encounter groups and other therapeutic sessions are organised. If residents display 'acting out' behaviour, they are corrected by staff or coordinators by means of verbal reprimands or learning experiences. These must not be confused with mere 'sanctions', as these reprimands or learning experiences are meant to support the resident.

Encounter groups are the central element of TC treatment. These non-hierarchical meetings take place

three times a week and last for about two hours. Residents (in mixed groups of 8 to 10 people) are required to confront the negative behaviour or attitudes of their peers. Because TC members are asked to 'act as if' they have no problems during their stay in the TC, the built-up tension leads to intense expressions of emotion during encounter groups. It can be considered as a tool for social learning, leading confronted residents to new insights into themselves and to identification with values of 'older', more experienced residents (Broekaert, 2001).

## 1.5. Overview of therapeutic community history in North America and Europe

Several studies have outlined the historical roots of TCs (e.g. De Leon, 2000; Vandevelde et al., 2004; Broekaert et al., 2006) and have differentiated three distinct generations of TCs.

### First generation (early 1950s)

The first generation can be described as the democratic TCs, which were inspired by psychoanalytical thinking (e.g. the Northfield Experiments) and sociotherapy/social learning (e.g. Jones, 1953). Haigh and Lees (2008, p. 353) identified that this model, which is sometimes also called the British tradition, is primarily concerned with 'the format of therapy — in groups and with a particular nature of relationships and democratic procedures — rather than a specific theoretic orientation'.

### Second generation (late 1950s to early 1960s)

The second generation involves the US tradition, which began with Synanon in 1958. Synanon was founded by a recovered alcoholic named Charles 'Chuck' Dederich. It was set up as a Utopian idealistic micro-society where recovering addicts lived and worked together, adhering to values such as truth, honesty, creativity, openness and self-reliance (Broekaert et al., 2000; Janzen, 2001). Dederich was inspired by the idealistic writings of R.W. Emerson, early Christian values, Eastern philosophy, moral re-armament (the 'Oxford groups', led by Frank Buchman) and Alcoholics Anonymous (AA) and its 12-step method (Broekaert et al., 2006, p. 2).

The 12-step method initiated by AA is one of the most widely used mutual aid models in addiction treatment

around the world (Magura, 2007). It has been adapted into the Minnesota model treatment — regarding addiction as disease, the professionals practising the model address the physical, psychological and spiritual aspects of addiction. The National Institute on Drug Abuse (NIDA) describes the goals and objectives of the Minnesota model as lifetime abstinence by following the 12 steps leading to recovery. Despite the historical link between TCs and AA, there has not been much research published on the connections between TCs and 12-step programmes (Troyer et al., 1995). While in some countries (e.g. the Netherlands, Sweden), many long-term residential programmes apply the Minnesota or 12-step model, these concepts should be differentiated from TCs as analysed in this publication.

An important difference between TCs and 12-step programmes is the fact that TCs do not refer to addiction as a disease. On the contrary, rooted in the humanistic psychology — characterised by a genuine belief in growth and the 'human potential' — the development of TCs could be regarded as a reaction against the medical model of addiction (Troyer et al., 1995). Furthermore, TCs do not refer in their concept to a 'higher power' as AA does in four of its 12 steps (Galanter, 2007). Another difference lies in the fact that confrontation (which presupposes that addicts should be considered responsible persons), a central element of the encounter groups in TCs, is not characteristic of AA or other 12-step programmes. More differences are described by De Leon (2000): the non-residential settings of AA versus the residential setting of TCs; the more severe client profile of TCs in comparison with AA; and differences in treatment objectives — becoming 'clean' (AA) versus a lifestyle change (TCs). Yet, although AA and TCs are clearly distinct, there seems to be a growing recognition from both sides of the complementary value of both treatment approaches. In some American TCs, 12-step programme components are increasingly being linked with TC treatment as a form of aftercare (Troyer et al., 1995).

Within six years of its development, Synanon had laid the basis for a number of TC programmes, including Daytop Village (1964) and Phoenix House (1967). This could be explained by Synanon's positive effects on the life of heavily addicted persons — a result not being achieved at that time by the traditional psychiatric hospitals, which failed to successfully treat addiction (Kooyman, 2001). This second generation of TCs was essentially behaviouristic, yet grounded in the American humanistic tradition. The TC movement eventually broke with Synanon for several reasons: the coerced lifelong commitment to the community, which evolved into a cult with Dederich as the charismatic leader; the use of sometimes hard learning and disciplinary techniques;

and the resistance to involving trained professionals (O'Brien, 1993).

### Third generation (late 1960s to 1980s)

From the 1960s and 1970s onwards, TCs were developed in several countries throughout Europe, an evolution that can be regarded as the third generation of TCs. European countries in which TC programmes were founded at that time included the United Kingdom (e.g. Phoenix House — Alpha House; Featherstone Lodge Project; Phoenix House; the Ley Community), Italy (e.g. L'Incontro; San Patrignano; CelS), Germany (e.g. Klinik Bad Herrenalb; Synanon; and Daytop Germany), Switzerland (e.g. Le Centre du Levant; Aebi Hus) (Kooyman, 2001), the Netherlands (e.g. Emiliehoeve) (Kooyman, 1992), Sweden (e.g. Vallmotorp Daytop) (Möller Teppema, 1984), Ireland (e.g. Coolmine Lodge) (Cullen, 1987), Belgium (e.g. De Kiem; De Sleutel; Trampoline; De Spiegel) (Broekaert, 1981; Maertens, 1999) and Finland (e.g. Pellas Community; Kisko). In the 1980s, TCs were founded in Spain (Programmas Libres de Drogas), Norway (Phoenix House), Greece (Ithaka/Kethea) (Broekaert et al., 2006) and some east European countries (e.g. Poland and the Czech Republic) after the fall of the Iron Curtain (see Chapter 4).

The beginnings of third generation TCs in the 1960s and 1970s took place in a period characterised by an emerging incidence of heroin addiction in several European countries. The increased availability of heroin and other illicit substances and the lack of effective responses led to a heroin epidemic in the mid-1980s. This resulted in the rapid spread of infectious diseases, mainly HIV/AIDS, and caused a dramatic growth in the number of drug-related deaths caused by drug overdoses. Injecting heroin, in particular, led to a 150 % increase in drug-related deaths between 1985 and 1995 (Hedrich et al., 2008). While most European countries (including Belgium, Germany, Greece, France and the Scandinavian countries) applied an abstinence-oriented drug treatment approach until the 1990s, the Netherlands, the United Kingdom and Switzerland embraced the harm reduction approach for reducing the negative health and social (e.g. crime) consequences of drug use from the 1980s onwards (Hedrich et al., 2008).

Around this time, TCs started to lose their dominant position in treating drug users. TCs faced many challenges in the 1990s, such as financial cutbacks as a result of the economic crisis, questions about the high dropout and relapse figures and changing drug policies primarily aimed at reducing drug-related harm. Problems with charismatic leadership in some TCs (e.g. in 'Le

Patriarche', France) and the switch from self-funded, independent organisations to mainstream services that are funded and controlled by the government led to the closure of some TCs and their replacement with smaller communities run by professionals instead of ex-addicts. More recently, the changing view on addiction as a chronic disorder and increasing criticism on the benefits of lengthy treatment episodes in closed residential settings by scientists, client advocates and service users have further challenged the development of TCs in many countries. The evidence-based paradigm that applies the randomised controlled trial (RCT) as the 'gold standard' for evaluating interventions has even questioned the validity of TCs, as they usually score low on 'evidence-based' rankings (Broekaert et al., 2010).

These challenges and evolutions have contributed to a decrease in the number of TCs in many European countries such as the Netherlands, Sweden, Switzerland and the United Kingdom (Broekaert and Vanderplasschen, 2003). To cope with these challenges, TCs have become more open towards harm reduction initiatives (e.g. introduction of methadone maintenance treatment modified TCs) and integrated elements from mainstream drug treatment and have become part of integrated treatment systems. Moreover, several TCs have been scaled down to smaller units or modified to meet the specific needs of subgroups of drug-using persons, such as women with children, dually diagnosed persons and prisoners.

### **Therapeutic communities in Europe today**

The divergent implementation of the TC as a treatment modality across Europe is influenced by various factors

such as cultural differences, political priorities, economic grounds and social policy options (Broekaert et al., 2000). Although essentially inspired by the US TCs, European TCs clearly have their own identity; the behaviouristic approach of US TCs has been complemented by European educational theories, psychoanalytical thinking, social learning, the involvement of trained professionals (instead of recovered ex-addicts serving as staff members) and a more family-oriented approach (Broekaert et al. 2006). There was also strong opposition in Europe to the hard learning techniques such as wearing signs and shaving hair — the so-called haircuts — and the extremely harsh confrontations in encounter groups (Goethals et al., 2011). This led to a European TC model that focused on a more balanced dialogue during encounter groups (Broekaert et al., 2004). TCs from various European countries today are collaborating in the European Federation of Therapeutic Communities (EFTC; <http://www.eftc-europe.com/>) and the World Federation of Therapeutic Communities (WFTC; <http://www.wftc.org/>).

Over the last 50 years, the TC has evolved from a long-term, generic treatment model to a modified and shortened model (modified TC) that is better tailored to the needs of specific groups of drug users, e.g. women with children, detainees and individuals suffering from other psychiatric disorders and that seeks to integrate evidence and belief in change (Goethals et al., 2011). Although the TC started as a belief-based treatment modality, building on a hierarchical structure, self-help principles and encounter groups as core therapeutic features, not inconsiderable attention has been given to the scientific underpinning of the method.



2



## CHAPTER 2

# The availability of therapeutic communities in Europe

This chapter presents an overview of the availability and implementation of therapeutic community treatment for addictions in Europe, featuring historical and current developments and national case studies.

The single integrative definition of TC as provided in Chapter 1 has been used to access and analyse the information presented.

### Methodology

Data were sourced from national stakeholders and other expert sources. Key informants were: programme directors or other individuals with a strategic overview of TC treatment provision at national level, who were also associated with the European Federation of Therapeutic Communities (EFTC), and the EMCDDA's network of national focal points (NFPs) in cases where EFTC contact did not exist or did not respond to our request. Other key sources included relevant chapters of the national reports provided by NFPs to the EMCDDA over the past five years. The aims were to identify the availability and capacity of TC treatment in all EU Member States, Turkey and Norway; and to identify historical developments and current aspects of TC treatment delivery and practice in a selection of European countries (Belgium, the Czech Republic, Spain, France, Poland, Sweden, the United Kingdom). An EFTC-network contact was not available or responsive in eight countries (Estonia, Croatia, Latvia, Luxembourg, Malta, Romania, Slovakia and Turkey); and in these countries, EMCDDA NFP contacts collaborated and provided data.

Twenty-eight of the 30 EMCDDA Member States reported data (Germany and Croatia being the exceptions). Data sources were the national country reports (if data on TC provision were reported

separately) or the EMCDDA NFP contact person in 15 countries. In 13 countries (Belgium, Bulgaria, Denmark, Finland, France, Hungary, Ireland, Italy, the Netherlands, Norway, Poland, Sweden and the United Kingdom), data were provided by national TC experts (usually TC directors). As data for the present study were sourced from beyond the Reitox NFPs network, in some countries the number of TC programmes identified differed from those provided in a companion report (EMCDDA Paper on residential treatment, in press). In some countries, TC is not officially recognised as a treatment modality, leaving it open to the national TC experts whether or not treatment facility is considered as providing TC interventions. Facilities that were not acknowledged by the national health or social authorities (e.g. religious communities) were not included in this number.

The number of treated clients per year is based on official records in all cases except Poland, where an estimation was provided. This number should represent the number of persons who have reportedly followed TC treatment for at least one day that year. For this study, 2011 was chosen as the year of reference, although for some countries the target information was not available at the point of data collection; data provided here present the most recent official data for each country.

## 2.1. Therapeutic communities in Europe today

In total, over 1 200 TC programmes were identified throughout Europe; only in Turkey was the TC as a treatment method not applied. Detailed information on the number of treatment facilities providing TC interventions in each Member State is provided in Table 2.1. Two-thirds of these programmes were reported from Italy ( $n = 798$ ) — with the Italian experts describing most of these programmes as small, family-type structures with a capacity of four to six residents, but adhering to international TC guidelines and standards (Andrea Ascari, personal communication, 19 April 2012). Outside Italy, just over 400 treatment facilities providing TC interventions were identified. While the number of TC programmes is low (fewer than five) in the majority of countries, it seems to be a well-established treatment modality in south (e.g. Greece, Spain, Italy, Portugal) and some east European countries (e.g. Lithuania, Hungary, Poland), with a total of 15 countries reporting five or more TC programmes.

Key informants in several European countries reported considerable problems for these programmes in terms of public funding for their work, resulting in the shutdown of some TC programmes (e.g. Norway, the United Kingdom) or a reduction in treatment duration (e.g. Czech Republic, Spain, Finland) or number of beds per unit (e.g. Latvia, Sweden). France is a clear exception in this sense, as the provision of TCs for addictions has been recently re-established (see section 2.2.2). The capacity of these programmes varies greatly, but is usually between 15 and 25 residents each. In some countries, the number of treatment slots per unit is clearly higher (e.g. Cyprus, France, Poland, Portugal, the United Kingdom). Owing to missing information on

the TC capacity in some large countries (e.g. Germany, Spain, Italy), the total capacity and number of treated cases can only be estimated. If the average capacity of TC programmes in Italy is set at six (the known capacity of a large number of small units) and in Spain is based on the EU average of 20, the number of places for drug addicts in TC programmes in Europe can be estimated to be over 15 000 beds (Table 2.1).

The estimated number of TC clients per year in each country is indicative of the turnover and average treatment duration in these countries. However, not all key informants were able to provide this information. In most countries, the duration of a TC treatment programme is between 6 and 12 months and the number of clients (persons retained in the TC for at least one night) per year is twice the available capacity. In some countries, this rate is considerably higher (e.g. Poland, Finland), owing to a high client turnover and/or the short length of (some) TC programmes. The low client turnover in other countries (e.g. Belgium, Cyprus, Ireland, Luxembourg) may be caused by high retention rates and adequate induction strategies to prepare drug addicts for TC treatment. It cannot be ruled out, however, that some of these differences were partially caused by the lack of standardisation in data collection between countries (e.g. registration of all intakes vs. only those who stayed at least one night).

Taking into account the different population sizes, the number of facilities offering TC per one million adult inhabitants was calculated (Table 2.1). A comparison between the number of facilities per one million adult population in each country reveals that proportionally the largest number is found in Malta and Italy (18 and 13, respectively), followed by Lithuania (6), Portugal (5), Slovakia (4) and Spain (3).

TABLE 2.1

Therapeutic community treatment provision in Europe (in 2011, unless otherwise specified)

Country	Reported by NFPs <sup>(1)</sup>	Reported by TC experts					
	Number of programmes	Number of programmes	Total capacity <sup>(2)</sup>	Number of clients per year	Average number of clients per programme	Number of treated clients per bed per year	Number of programmes per one million population
Belgium	14	8	204	357	25	1.75	0.7
Bulgaria	2	3	60	140	20	2.33	0.4
Czech Republic	18 <sup>(3)</sup>	10	160	394	16	2.46	1.0
Denmark	14	1	15	41	15	2.73	0.2
Germany	0	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Estonia	1	1	26	82	26	3.15	0.7
Ireland	13	2	45	75	22	1.67	0.4
Greece <sup>(4)</sup>	6	11	417	980	38	2.35	1.0
Spain	131	129	n.a.	8 134	n.a.	n.a.	2.7
France	11	11	380	n.a.	34	n.a.	0.2
Croatia	30	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.
Italy	708	798	n.a.	n.a.	n.a.	n.a.	13.2
Cyprus	1	1	50	86	50	1.72	1.3
Latvia	3	2	6.5	14	3	2.15	0.9
Lithuania	15	19	330	620	17	1.88	5.9
Luxembourg <sup>(4)</sup>	2	1	25	44	25	1.76	2.0
Hungary <sup>(5)</sup>	10	14	374	738	27	1.97	1.4
Malta	3	7	129	360	18	2.79	17.5
Netherlands	4	8	262	555	33	2.12	0.5
Austria	0	9	269	599	30	2.23	1.1
Poland	59	85	2 852	10 000	34	3.51	2.2
Portugal	68	57	1 977	3 584	35	1.81	5.4
Romania	5	3	25	n.a.	8	n.a.	0.1
Slovenia	7	4	112	n.a.	28	n.a.	2.0
Slovakia	13	19	347	857	18	2.47	3.5
Finland	0	4	58	264	14	4.55	0.7
Sweden	0	1	11	27	11	2.45	0.1
United Kingdom	18	10	454	851	45	1.87	0.2
Turkey	0	0	0	0	0	0	0.0
Norway	4	5	123	323	25	2.63	1.0
<b>Total</b>	<b>1 160</b>	<b>1 223</b>	<b>8 449.5</b>				

n.a.: not available.

<sup>(1)</sup> Data on TC programmes reported in this publication are sourced from beyond the Reitox NFPs. In most countries, a different number of TCs in each country was reported in the context of a project focused on residential treatment in Europe and informed by the Reitox network of NFPs (EMCDDA Paper on residential treatment, in press). The results from the two different data collections are presented in separate columns; the figures reported by TC experts are used in the present analysis. For Germany and Croatia data have been reported only by the NFPs.

<sup>(2)</sup> Estimation.

<sup>(3)</sup> Czech Republic: reporting range: [15–20,  $n = 18$ ].

<sup>(4)</sup> 2010 data.

<sup>(5)</sup> 2008 data.

## 2.2. Development and current therapeutic community practices in selected EU countries

The above-mentioned figures (Table 2.1) reflect the present-day situation, which may not be representative of the situation in the past. Some countries have had a tradition of TCs for more than 30 years (e.g. Belgium, Spain, Italy), while other countries have closed down several TCs (e.g. the Netherlands, Sweden) or transferred them to correctional settings (e.g. Spain, the United Kingdom). In most east European countries, TCs for addictions were implemented only after the fall of the Iron Curtain (e.g. Bulgaria, Hungary), while France reintroduced TCs after the closure of the patriarch communities in the 1980s.

Consequently, seven countries have been selected that represent different positions along the continuum of implementation of TCs in Europe: Belgium, the Czech Republic, Spain, France, Poland, Sweden and the United Kingdom. In each country, history, current practice, position in the network of services, staffing, quality control, funding and certification were studied, and recent challenges and trends regarding treatment in TCs for addictions were identified. First, the TC situation in each of the selected countries is presented. The seven case studies are then compared and critically analysed from a European perspective on the history and future of TCs for addictions. Information on these country studies was based on EMCDDA country reports from 2000 to 2010 and contacts with TC experts in each country. The case studies are presented in the historical order of implementation of drug-free TCs: the United Kingdom, France, Sweden, Belgium, Spain, Poland and the Czech Republic.

### 2.2.1. TCs in the United Kingdom

#### History

To understand the impact that concept-based TCs have had upon other UK drug treatment modalities, it is important to understand not only the general mood and nature of those other services at the time of their transposition but also the changes that had been seen in the treatment of the mentally ill and the socially dislocated during the previous decades. In post-war United Kingdom, drug addiction was viewed as a US disease that would, presumably, respond to US treatment regimes (Yates, 2011). The work of Maxwell

Jones, Tom Main and others in the development of so-called 'democratic' TCs during and shortly after the Second World War has been described in some detail (Kennard, 1983; Kooyman, 2001). These developments were significant elements of broader changes within psychiatric treatment as a whole, including the introduction of psychotherapy and pharmacological treatment. In the 1960s, the Scottish psychiatrist R.D. Laing took the then remarkable step of moving his patients out of the psychiatric hospital altogether and establishing the anarchic TC, Kingsley Hall. In earlier years, Homer Lane (before the First World War) and David Wills (between the two world wars) developed the first TCs for 'maladjusted' children, including confrontational group work and a focus on self-governance. These developments in psychiatry and youth care may have eased the establishment of the early addiction TCs, as they began to be imported into Europe in the early 1970s, and ensured that these apparently new ideas were accepted more readily than might otherwise have been the case.

These new TCs soon began to exert an influence upon the field of drug treatment in the United Kingdom. By the mid-1970s, concept-based TCs accounted for almost half of the residential rehabilitation beds in the United Kingdom (Yates, 1981). Although this is an impressive 'territorial' claim, in terms of numbers of drug users presenting for treatment, TCs were actually a relatively small player, as residential treatment was a peripheral component of the UK treatment response and the numbers of individuals actually treated were relatively modest. However, their influence was felt throughout the treatment field. By the mid-1970s, medical staff working in drug dependency units were beginning to incorporate some of the techniques of TCs into the clinical setting. The aim was to provide a more therapeutic regime than the sterile interaction that had developed, which was largely dominated by staff–patient manipulation around dosage and type of substitute prescription (Mitcheson, 1994). Non-residential treatment services, were also influenced by TCs, with some developing pre-entry 'induction programmes' (Strang and Yates, 1982), while others began to undertake group work modelled upon that found in TCs.

Despite their early promise and radical approach, TCs in the United Kingdom were slow to adapt to the changing demography as the number of drug users began to escalate at the end of the 1970s (Yates, 1992). With the increase in drug users came an expansion in drug treatment services, and TCs struggled to have an influence in what was now a substantial treatment field dominated by community-based services. This changing emphasis towards outpatient or ambulatory treatments

echoed wider developments in UK psychiatry and social welfare. Increasingly, throughout the 1980s, the trend was away from large inpatient psychiatric hospitals and towards a range of treatments in the community.

### Current practice

Owing to the spread of HIV/AIDS, the new political imperative was harm reduction rather than recovery, and TCs found themselves on the margins of the debate. This increasing marginalisation was reinforced by changes in the UK public funding of care which transferred the responsibility for authorising payment for residential care away from the UK-wide social security system and placed it in the hands of local government officials. This left TCs — which, in the United Kingdom, had traditionally served a geographically diverse population — negotiating per capita funding with a large number of local authorities that were only too aware that the purse was limited and that other causes needed to be funded from within the same allocation. As a result, most TCs in the United Kingdom found themselves under pressure to shorten programme lengths, abandon practices with which some funders were uncomfortable, and ensure a higher ratio of ‘professional’ staff. At present, there are 10 TCs that have a total capacity of 454 residents. Paradoxically, during the same period, TCs began to be explored by treatment planners within the UK prison system, as there is good evidence for TC interventions in custodial institutions (Inciardi et al., 2004).

### Recent evolutions and future challenges

In order to ensure their continued existence and integrity in the future, TCs will need to target those areas where they can make the most impact and achieve the most good. This means designing modified TCs for particularly vulnerable populations, such as the homeless and those with co-existing disorders, and establishing TCs in areas where they are likely to attract a higher proportion of their traditional client group, such as in prisons and detention centres. It also means TCs working to reposition themselves as a ‘senior partner’ in the growing UK recovery movement.

The past five years in the United Kingdom have seen a resurgence of interest in recovery as a central focus of addiction interventions. In part, this has grown out of a sense of dissatisfaction among the media, policymakers and service planners with the limited objectives of current mainstream addiction treatments. This was perhaps best exemplified by the public debate that followed the BBC’s challenging of the National

Treatment Agency’s annual report in 2007, which appeared to show that only 3 % of the treatment population was leaving treatment drug-free (Ashton, 2008). In addition, the interest in recovery has been a grassroots movement, led by service users themselves expressing their disenchantment with a treatment regime that appeared to place a higher priority on infection control and reductions in offending than on their aspirations to achieve abstinence-based recovery.

### 2.2.2. TCs in France

#### History

The 1970s saw the establishment of concept-based TCs for the treatment of addiction in Europe. During this period TCs in France took up a particular position. After living in camps and prisons for five years, Lucien Engelmajer, later called the Patriarche, a Jew who was ready to become a rabbi, began supporting vulnerable groups of people. He started taking care of children of deported and executed parents, searching for foster homes, and organising living and vacation centres (Engelmajer, 1984, p. 13). He later began working with drug addicted persons, and, together with his wife Rena, a school teacher, created a living centre for addicted people at ‘La Boère’ in Saint-Paul-sur-Save. In 1974, with the support of Professor Claude Olievenstein, a psychoanalytically oriented psychiatrist, Engelmajer started ‘l’Association Le Patriarche’ (Wikipedia, 2012).

La Boère offered its residents a daily life routine based on work and arts and crafts activities, striving for a balance between freedom and responsibility. The ‘direction départementale des affaires sanitaires et sociales’ supported the organisation with a daily contribution of EUR 40 per person (Engelmajer, 1984, p. 200). Starting as a small organisation, it soon became larger. In 1984, it already numbered more than 100 centres in Europe taking care of 5 000 addicts (Arcas, 2010). In 1983, the rise of the AIDS epidemic led to the start of ‘Espaces de santé pour les séropositifs’, which underpinned the further financial support by the administration (Vernette and Moncelon, 1996). At the end of the 1980s, the organisation numbered 5 000 residents in 210 centres located in 17 countries, including North, Central and South America (Dianova, 2012).

While the concept-based TCs inspired by the US Phoenix House and Daytop models were blossoming in other parts of Europe, in France social workers opposed the US methods based on strict hierarchy, sanctions,

humiliations and mechanistic approaches (Castagné, 2006).

'L'Association Le Patriarche' survived by the profit-making system it had developed. The residents' therapy included renovating cheaply bought real estate that could then be sold at a higher price. Some of the ex-residents who had remained in TC treatment for considerably long periods of time went on to become unpaid addiction therapists in the TC programmes, raising questions about the motives behind Engelmaier's work. In 1995, the French commission of inquiry on sects (La Commission d'enquête sur les sectes) unanimously classified 'Le Patriarche' as a sect (Prevensectes, 2012) and the interministerial delegation on the fight against addiction (MILDT: Mission Interministérielle de Lutte contre la Drogue et la Toxicomanie) stopped funding the organisation (Bourgeoin, 2006).

### Current practice

In 1998, Engelmaier was forced to resign from his position by his own board of directors. Since then, 'L'Association Le Patriarche' has changed direction and operates under a new name, Dianova, in the field of youth care and community-based social work. The organisation is represented in 11 countries across Europe and the Americas. Alongside Dianova, other TC programmes are 'Le Bouriflet', founded in 1978 by the association Sato Picardie, and 'Le Mas Saint-Gilles', established in 1994. The latter, with its aim of reintegration into society and education of residents, radically broke with the tradition of 'Le Patriarche' with its focus on stimulating dialogue and normal living situations.

### Recent evolutions and future developments

The further development of TCs for the treatment of addiction in France was, to a large extent, a result of a governmental plan from 2004 to 2008 that encouraged and supported the establishment of TC programmes (Jourdan, 2007). To date, 11 TCs have been established and operate in France, looking after a total of 380 residents. Two of these TC programmes were opened at the end of 2011.

In conclusion, French TCs for the treatment of addiction are currently undergoing considerable expansion. The MILDT not only subsidises these new initiatives but also takes care of the training and professional development of TC staff members, thus guaranteeing a professional

approach, away from the charismatic-type leadership features that were once typical at 'Le Patriarche'.

### 2.2.3. TCs in Sweden

#### History

Since the mid-1960s, Sweden has faced a drug problem, the initial response to which included medical treatment provided within psychiatric units. In the early 1970s, TC programmes began to be established, which coincided with a general expansion of the whole drug treatment and care system, prompted by the AIDS epidemic.

Boekhout van Solinge (1997, p. 122) noted: 'Of the different forms of drug treatment, therapeutic communities have for a long time been the most dominant. Communities are based in the rural areas of Sweden, where it was not uncommon for a drug addict to spend a period of two years. Many of the treatment institutions are non-governmental: 65 % of all institutional care is privately run. This implies they have to sell and market their services to the government institutions, either at the national level (the Board of Health and Welfare) or at the local level (the social services).'

At the heart of the Swedish ideal for a perfect society sits a drug-free life, and welfare formed fertile ground for the development of the TC philosophy and programmes. In 1973, Lars Bremberg founded Vallmotorp, on a professional and sociopedagogical basis. It was located in Katrineholm, west of Stockholm. It functioned on the basis of transactional analysis, Gestalt therapy and Maxwell Jones' democratic TC approach (Broekaert et al., 2006). The TC was supervised by external experts in transactional analysis therapy (Johnson, 2011), a humanistic psychology approach that functioned as the bonding force of the educational process. Vallmotorp comprised a varied staff: psychologists, educators, social workers, teachers, and ex-addicts and other non-professionals with life experiences. In Vallmotorp, residents were called 'students' and Lars Bremberg 'rector', to emphasise that Vallmotorp was a school for life.

In 1980, Lars Bremberg created the 'Daytop Sweden Foundation'. Daytop Sweden was directly influenced by Daytop New York. In contrast with Vallmotorp, Daytop Sweden was a hierarchic drug-free concept TC and grouped together with Ribbinglund Hospital and other TCs (Broekaert et al., 2006). Subsequently, in 1985, the Nordia foundation was established as the first Finnish-



speaking TC, and the Evada foundation began operating as a halfway house in Stockholm (Görransson, 1994). The four independent foundations collectively formed an umbrella organisation. In the mid-1980s, the organisation employed 250 staff members and provided treatment and care for 600 drug users.

Since the end of the 1980s, the Swedish TC network has been disrupted following reductions in funding. Commentators (e.g. Segreus, 2011) have noted a number of factors implicated in the dismantling of the Swedish TCs, including but not limited to: (i) the financial crisis of the 1990s and the resulting scarcity of financial resources; (ii) the shift of political support to localising addiction treatment in the community as opposed to an isolated programme away from the drug users' environment; (iii) the lack of evidence to support the effectiveness of the TC model; and (iv) the fact that the harsh encounter methods used in TCs were not compatible with the Swedish mentality.

### Current practice

At present, there are almost 300 residential recovery centres in Sweden. Most of them offer 12-step programmes with durations of 29 days to 3 months. According to the official list of HVBs [Hem för Vård och Boende (Homes for Living and Treatment)], there are 45–50 residential drug treatment programmes for adults in Sweden (Socialstyrelsen, 2012) and a number of residential treatment programmes for young people with drug-related problems.

## 2.2.4. TCs in Belgium

### History

In the 1960s and 1970s, an increase in the use of various illicit substances such as marijuana and LSD (lysergic acid diethylamide) could be observed in Belgium. Use itself increased significantly, as did the number of associated problems. Most services that specialised in providing treatment to persons with alcohol or mental health problems were not keen to provide treatment to those persons with illicit drug problems (Vanderplasschen et al., 2002), predominantly because they believed that illicit drug users would not comply with the prevailing treatment regime. Also, the drug users themselves were not inclined to seek treatment in traditional mental health care settings, as they were afraid of facing judicial consequences

(Casselmann, 1971). As a result, specialised treatment initiatives for illicit drug users were set up. These initiatives were often based more on an educational approach rather than a medical treatment model.

In 1972, the first residential treatment centre specialised in the treatment of persons with alcohol and drug problems was established in Belgium. Gradually, the treatment of young drug users in this clinic developed into a drug-free, concept-based TC, called De Kiem (Broekaert, 2006b). De Kiem was established under the impulse of Eric Broekaert (Ghent University, Department of Orthopedagogics), who had studied the Synanon movement in the USA. In 1974, the TC De Sleutel was founded by Johan Maertens. Both TCs were in close contact with the TCs Emiliehoeve and Essenlaan in the Netherlands and were therefore directly influenced by Phoenix House London and Phoenix House New York. More TCs followed (Broekaert et al., 2002). In 1978, TC Choisis, inspired by La Boère in France, was soon transformed into TC Ellipse, a psychoanalytical residential treatment programme for drug users. In 1979 and the 1980s, TCs De Spiegel, Les Hautes Fagnes and Katarsis Trempline followed. Finally, in the mid-1990s, two TCs were established with a strong focus on dual diagnosis. In 1994, De Sleutel set up a second TC, specifically targeted at persons with a dual diagnosis, and in 1995 a TC for persons with drug problems, De Klimop (Rekem), was developed within a psychiatric hospital.

### Current practice

In 2012, there were eight residential TCs for drug addicts in Belgium. Belgian TCs are drug-free treatment programmes predominantly oriented towards persons with illicit drug problems. This is explicitly stated in the contracts of the various TCs with the National Institute on Health and Disability Insurance (RIZIV/INAMI), which subsidises TCs in Belgium. Some of the TCs allow persons with alcohol problems by way of an exception. One of the eight TCs (TC Hautes Fagnes) has proportionally more persons with alcohol problems. Two TCs (TC De Sleutel for dual diagnosis and TC Klimop) are modified TCs targeted at persons with dual diagnosis.

Two Belgian TCs (De Kiem and Trempline) have a so-called 'reception centre'. This reception centre can be seen as a preparatory phase preceding admission to the TC. Other TCs have set up crisis intervention centres aimed at detoxification, motivation and orientation. When entering one of the Belgian TCs, persons have to be fully detoxified from methadone as well as any other substitution medication. Residents who have completed the TC programme can move on to a halfway house,

which is aimed at facilitating reintegration into society. All Belgian TCs are members of the EFTC and are assumed to respect the 'standards and goals for therapeutic communities', which have been adopted unchanged from the WFTC.

Currently, the eight Belgian TCs have a total capacity of 204 places (range: 15–35 places) and welcome on average 45 new clients each year (range: 20–95). Nearly all of the staff members are paid; few volunteers are involved on a day-to-day basis in Belgian TCs. Most of the staff members are professionals with either a bachelor's degree in orthopedagogy, nursing or education or a master's degree in psychology, orthopedagogics or criminology. In all TCs, general practitioners and psychiatrists are part of the multidisciplinary treatment staff. Proportionally, the number of staff members with a non-medical background is considerably greater than those with a medical background. Some of the TC staff members are ex-addicts, but they make up a small part of the total number of staff members working in TCs. Furthermore, these ex-addicts are encouraged to pursue a bachelor's degree in social work or orthopedagogy in a part-time study programme while on the job.

In order to pass on the knowledge, skills and attitudes associated with working in a TC environment, most of the Belgian TCs hold on to a 'resident internship' for all new staff members. This 'resident internship' allows new staff members to get to know the TC principles and methods from the inside out by becoming a resident for a period of time in one of the other Belgian TCs. Furthermore, the TCs also provide internal training opportunities for both new and more experienced staff members and they are united in the Belgian Federation of Therapeutic Communities (BFTC), which organises annual workshops for all its members on a topic of interest. Finally, staff members of TCs participate in generic training programmes organised by umbrella organisations or training centres.

### Recent evolutions and future challenges

Over the years, Belgian TCs have evolved in certain areas: a shift in the primary drugs that residents use upon admission; more attention to women; greater involvement of the family and the broader social network of residents; more attention paid to psychiatric comorbidity; and a closer collaboration among substance abuse treatment providers and with other sectors. In TCs, a shift has been observed in the primary substance that people misuse upon admission (increase in the use of cocaine and amphetamines; stabilisation of heroin problems),

although this has not fundamentally changed the orientation and focus of the programmes. At present, treatment providers are more often confronted with treatment requests from older (heroin) users but have generally set a limit at the age of 40. Gradually, more attention has been given to the specific position of women in TCs. The majority of TC residents are male, but certain TCs organise specific women's groups and each month a women's day is organised by the BFTC on which female residents of the various TCs can meet and engage in specific activities. In most TCs, family workers are part of the TC staff. TCs have also increased the attention paid to the children of (future) residents. Some TCs run specific initiatives for mothers (and fathers) who want to enter the TC programme while staying together with their children. TCs have further become more aware of psychiatric comorbidity among residents and have gradually become more open towards the use of prescribed psychoactive medication in cases of severe mood, anxiety, personality or other psychiatric disorders. In some TCs, there is the possibility of detoxifying from methadone in the reception centre in order to lower the threshold for entering the TC.

TCs were the first specialised treatment initiatives for drug users in Belgium. Over the years, other types of treatment modalities and facilities specifically targeted at drug users have been established, such as daycare centres, detoxification programmes, social working places, prevention programmes, harm reduction initiatives and medical social reception centres providing methadone treatment. An important recent initiative was the creation of a drug-free wing ('D-side') in one of Belgium's prisons, established with the help of TC staff members. Most of the TC founders played an important role in the development and establishment of a large part of these initiatives and are now engaged in a wide variety of treatment initiatives for both in- and outpatients (e.g. De Kiem, De Sleutel and Trepmpoline). Although Belgium now has a large variety of services involved in the treatment and support of drug users, the communication and cooperation between them has often been very limited (Vanderplasschen et al., 2002). Over the past decade an increase in (regional) collaboration efforts has been observed within the substance abuse treatment sector and also between this sector and other sectors (e.g. mental health care, judicial system), but large regional variations in levels and intensity of collaboration can be seen (Vanderplasschen et al., 2002).

In the (near) future, TCs, as well as other types of treatment modalities, will no longer be governed by the federal authorities, but by the regional and state authorities. At present, politicians and policymakers are



preparing this important shift, but little information is currently available. However, this will certainly imply administrative and financial consequences. In times of scarce financial resources, it can also be expected that all treatment providers will have to be able to demonstrate some proof of effectiveness in order to justify the investment of public resources.

### 2.2.5. TCs in Spain

#### History

In response to the emerging heroin epidemic in the mid-1970s, the first TCs for drug addicts were established in Spain in 1979 (Comas Arnau, 1988). These TCs were inspired by 'Le Patriarche' communities in France and were run by ex-addicts, without public financial resources. By 1983, there were about 13 drug-free self-help TCs in Spain that had been created with the help of private and public institutions (Broekaert et al., 2006). In 1984, Proyecto Hombre — modelled after the Italian Progetto Uomo, where the first Spanish professionals (Juan Francisco Orsi and Aitor Aresti) were trained — founded its first TC. Owing to the increasing number of drug problems in the 1980s, Proyecto Hombre <sup>(1)</sup> opened TCs all over Spain during that period.

From the 1990s onwards, the harsh TC treatment methods of the early days were replaced with more dialogue and open communication, and democratic TC principles (see Bridger, 1990) were introduced in concept TCs. Given the strong connection with CelS (Centro Italiano di Solidarietà) in Italy, a cross-fertilisation of drug-free and democratic TC traditions has characterised the development of TCs in Spain from the beginning. Since the official introduction of methadone maintenance treatment (MMT) in 1996, the number of centres offering MMT and the number of users of this service grew constantly, while the number of cases treated in detoxification hospitals and TCs dropped (EMCDDA country report, 2000). More recently, TCs have been adapted to serve the special needs of various groups of drug addicts such as adolescents, persons with dual diagnosis and mothers with young children. Such modified TCs have been established in psychiatric hospitals, prisons and methadone maintenance services.

<sup>(1)</sup> Proyecto Hombre should not be regarded as a treatment method, but rather as a philosophy with a focus on humans and their development. At the moment, Proyecto Hombre is one of the largest treatment networks for drug addicts in Spain, including various types of abstinence-oriented treatment modalities (e.g. TCs).

As in other European countries, the TCs along the lines of 'Le Patriarche' have evolved rather isolated from the mainstream TC movement, as they are often closed communities and can include unsavoury businesses under threat of becoming a cult (Broekaert et al., 2006). Therefore, 'Le Patriarche' started a process of internal restructuring and changed its name to Dianova. More democratic principles were adopted and services professionalised (Comas Arnau, 2006). Although TC networks run by Dianova and Proyecto Hombre are partially supported by private resources, there are also several public and private, non-governmental (publicly funded) TCs in Spain.

#### Current practice

A review of recent national reports on the drug situation in Spain shows that the number of TCs and TC residents has remained rather stable, but these services are not spread equally across the country. According to the latest report of the National Plan on Drugs (Plan Nacional sobre Drogas, 2009), the number of TCs was 129 in 2009, 68 of which were managed by non-governmental organisations. The total number of residents in 2009 was 8 134. Proyecto Hombre is one of the largest organisations providing TC treatment in Spain and consists of 32 TCs all over Spain, including conventional TCs, modified TCs for dual diagnosis, three TCs in prison (Orense, Córdoba and Madrid/Soto del Real) and some urban TCs (Valladolid, Burgos, Almería).

According to the 2011 national report, Spain has an extensive network of (outpatient) resources for treating drug-related problems, including risk and harm reduction programmes, crisis and detoxification centres, training workshops and substitution treatment. TCs have been, and continue to be, a key link in this chain of services and have progressively adapted to changes in the population for which they provide care. TCs have evolved from rather isolated programmes into specialised residential environments that are part of a comprehensive network of support services for drug addicts. A TC programme is specifically recommended for drug users with serious personality disorders, limited family support and multiple previous treatment failures.

Spain's TCs are structured educational environments in which drug users live together to achieve social reintegration without drugs (Comas Arnau, 2010). They integrate various psychological theories (i.e. behavioural, humanistic and psychodynamic) and therapeutic approaches and can be regarded as places for social learning (García Llana, 2010). The treatment programmes typically consist of three phases: 'acogida'

(outpatient motivational, preparatory programme), TC treatment and the re-entry phase (preparation for social reintegration, including job counselling and individual action plans). Treatment duration varies from TC to TC and from case to case, but in general the 'acogida' phase lasts 6–9 months, followed by an inpatient stay of 9–12 months. Not all TC programmes are preceded by an outpatient motivational phase, but the re-entry programme is strongly recommended after TC treatment. The TC phase is in principle residential, but where there is sufficient family support it can be replaced by day treatment programmes, based on TC principles. As methadone is the standard treatment for heroin users in Spain, most TC programmes admit persons on methadone, although the ultimate treatment objective is abstinence.

The number of professionals working in TCs in Spain is around 1 500. Most TCs (in particular the Dianova and Proyecto Hombre TC programmes) employ recovered ex-addicts, who make up 20–30 % of all staff in Proyecto Hombre. Other, qualified professionals in TCs are, among others, psychologists, educators, pedagogues, social workers, nurses and medical doctors. A division between so-called 'professional' and 'non-professional' TCs (that employ ex-addicts) has been observed. Around 60 % of all TCs in Spain also employ volunteers, some of whom are relatives of drug addicts and who fill administrative, domestic or treatment-related functions (Comas Arnau, 2006). The involvement of volunteers is regarded as being of vital importance for promoting the social inclusion of drug users.

Continuing professional training and development ensures the quality of drug treatment provision in TCs in Spain. Since 1990, Proyecto Hombre has used a training institute in Madrid for the training of all staff members into the TC method, based on a published set of guidelines for the provision of TC treatment (Yubero et al., 2007a, b).

Three out of four TCs in Spain are run by private organisations, whereas the remainder depend on public authorities such as autonomous communities, provinces and cities (Comas Arnau, 2006). TCs can be accredited by state, provincial or local authorities. Quality control is limited to sanitary and safety inspections and regulations regarding the number and categories of professional staff.

Although public TCs receive funding from the Ministry of Health, some non-governmental organisations (e.g. Dianova, Proyecto Hombre) use additional private funds. Consequently, treatment fees may differ substantially between TCs; for example, in Proyecto Hombre residents

are requested to pay for their treatment according to their ability.

### Recent evolutions and future challenges

One of the recent evolutions in TC treatment in Spain is the establishment of prison TCs. In 1998, the first TC in prison was started in Madrid (Soto del Real prison), followed by a second case in Ourense in 2001 (Pereiro de Aguiar prison). In addition to these penitentiary TCs, so-called 'therapeutic modules' have been introduced to motivate drug users to continue treatment after their prison sentence. Furthermore, the number of drug-using prisoners diverted from prison to community TC treatment each year is slightly increasing. The growing interest of the judicial authorities in TC treatment is not reflected in the policy of the Ministry of Health, and several community TCs have been closed in recent years.

Given the economic recession in Spain and the rest of Europe, governments may further save on long-term substance abuse treatment, which will particularly endanger publicly funded programmes (Regal Ledo, 2010). Moreover, financial cutbacks can affect the integrity of the TC model (e.g. number of staff, duration of treatment). Therefore, continual training in the TC method is necessary to safeguard this unique approach. Recently, more severe neurological damage and a more severely deteriorated physical condition have been observed in drug users entering TC treatment, which brings about new challenges.

Furthermore, the high unemployment rates in Spain hamper the reintegration of drug users into society, as relapse is more likely without having a structured day provided by work. As a consequence of the reduced financial resources, drug addicts are more frequently referred to evangelical/religious communities by professional services (Comas Arnau, 2006). Residence in these communities is usually free of charge, but they are not controlled or accredited by a governmental authority. Such religious communities should not be regarded as concept TCs, as the focus in these communities is on physical work and praying.

### 2.2.6. TCs in Poland

#### History

In the late 1970s, the number of people addicted to *kompot*, or 'Polish heroin', spread rapidly, but the regime

of that time denied the existence of drug addiction in the socialist society, so no specialised drug treatment services existed. Drug treatment, including detoxification and psychotherapy, was provided in psychiatric hospitals. It was in such circumstances that Marek Kotański, a charismatic psychologist, established the first TC for drug addicts, called MONAR. This TC was modelled on the US TC Synanon. MONAR became officially registered as a legal entity and non-profit association in 1981 and has since established five TC programmes in different regions of Poland.

During the late 1980s, when Poland was confronted with the AIDS epidemic, MONAR became an asylum for HIV-infected drug addicts. During this period, the association established a special TC house for women and children with HIV (Koczurowska, 2006). In the 1990s, after the end of the communist regime, MONAR opened other services that were modified to fit the needs of socially disadvantaged groups including homeless and unemployed drug users, juvenile delinquents and ex-prisoners.

Other organisations that began delivering TC treatment for addicts, based on the MONAR experience, included the non-governmental organisation KARAN (initiated by the Catholic Anti-Drug Movement), which opened a TC for adolescent addicts; the Society for Drug Prevention, which established another TC for adolescents; the Catholic Centre for Upbringing and Resocialization for Youth; and TC 'Familia', established especially for the treatment of dually diagnosed clients (Koczurowska, 2006).

### Current practice

A review of the EMCDDA country reports (2000–09) showed that while other forms of treatment, such as harm reduction and substitution treatment, found their way in the Polish treatment system in the early 1990s, drug-free TCs have been considered to be among the more widely accepted types of treatment. In contrast to most other European countries, the Polish substance abuse treatment system invested most of its resources in residential treatment services as opposed to ambulatory or outpatient treatment services. Generally, drug addiction treatment is provided by non-governmental organisations, public health institutions and private organisations. Treatment in these facilities is free of charge, except for the private drug clinics and private practices. The main types of substance abuse treatment services are inpatient and outpatient centres, detoxification wards (mainly established in hospitals), drug wards in prison and post-rehabilitation programmes. Drug-free TCs are part of the inpatient services.

Currently, the treatment system for drug addicts includes 85 TCs (2 852 beds), which, within a given year, serves over 10 000 residents in total (National Bureau for Drug Prevention, 2011). The majority of the TC programmes are run by non-governmental organisations, funded by the National Bureau for Prevention of Drug Abuse. The National Bureau sets the quality standards for TC treatment provision, to which TCs are requested to adhere (Moskalewicz, 2009). In addition to standard adherence, all publicly funded TCs are expected to meet legally defined criteria regarding staff, types of service provision and professional and ethical standards (Koczurowska, 2006).

TC programmes today are adapted to clients of different ages and specific needs. There are programmes for children and adolescents up to 19 years old, for adults aged 19–25 years and for adults over 25 years old. These programmes differ in the recommended duration of residential treatment: the short-term (3–6 months) and medium-term (6–12 months) programmes focus on young people and persons with less severe drug problems, while the long-term (12–18 months) programmes look after adults with a long-standing or more severe drug-related problem. In accordance with the TC model, all clients go through an adaptation stage (typically in an outpatient setting), a residential stage and a re-entry (aftercare) stage. Clients are referred to TCs by specialised counselling units, family doctors or courts (Koczurowska, 2006). Upon entry to the TC, clients have typically undergone detoxification and are free from drug use including methadone and other substitution medications.

### Recent evolutions and future challenges

One of the recent evolutions in TC treatment in Poland is the establishment of prison TCs (Moskalewicz, 2009). By 2009, 16 medium-term (six months) drug-free treatment programmes had been implemented in specific therapeutic wards of correctional institutes. These programmes were based on specific TC elements, ingredients of the Minnesota model, social learning and cognitive–behavioural interventions. According to Charmast Masza (personal communication, 5 June 2012), no current evaluation research exists on TC treatment. However, the Polish Federation of Therapeutic Communities is preparing an in-depth assessment of Polish TCs.

### 2.2.7. TCs in the Czech Republic

#### History

Before the Velvet Revolution (1989), illicit drug use in former Czechoslovakia was limited, because of the strong social control and closed borders, and mainly concerned home-made products such as marijuana, hydrocodone and methamphetamine (pervitin). Following the splitting of Czechoslovakia in 1993 into the Czech and Slovak Republics, a drug epidemic was observed in the Czech Republic as a result of political and economic reforms, changing values and lifestyles, weakened outer border and social controls, and, because drugs were a taboo, the absence of drug prevention and legislation.

Long before the late arrival of illicit drug problems in the Czech Republic, the first TC-based hospital ward for alcoholics was established in 1948 by Jaroslav Skála in Prague (Apolinář). Later, similar (democratic) TCs were opened for persons with neuroses, psychoses and personality disorders, with an emphasis on heavy physical and mental work and taking responsibility for one's own life. Since this approach appeared to be unsuitable for young drug addicts with immature personalities, specific TCs for this population were established from the 1990s. Czech drug-free TCs developed quite independently from TCs for addictions in the rest of Europe, and are clearly indebted to the long national TC tradition (Bém et al., 2003). An important influence in this TC movement is the role of SUR, a psychotherapy training centre named after its founders, Skála, Urban and Rubeš, who were involved in the development of the first TCs in the Czech Republic. Until now, most TC professionals have followed psychotherapy training in SUR, explaining the strong psychodynamic and group dynamic orientation in Czech TCs.

#### Current practice

In 2010, 10 TCs for the treatment of addictions were subsidised by the Czech Government Council for Drug Policy Coordination (GCDPC). The overall capacity of these TCs was 160 beds, and a total of 408 clients were treated in these programmes in 2010 (Mravčík et al., 2011). The exact number of TCs is difficult to determine, as two TCs are certified by the Czech Association of Non-governmental Organisations for Drug Addicts but not by the GCDPC.

Czech TCs are usually small (15–20 residents) and their functioning resembles a family hierarchy. The

therapeutic programme consists of group and individual therapy, in combination with work (e.g. household, kitchen, garden) and educational activities. The treatment duration varies between 10 and 12 months. The residential TC programme is usually preceded by compulsory detoxification, which is provided in psychiatric hospitals (Adameček, 2007). Residents are prepared for reintegration into the community during the last phase of treatment and this is sometimes followed by continuing care. Methadone and other substitution medicines are typically not used in most TCs, although this policy is applied in a more flexible way in cases of dual diagnosis (Sobotka, 2007).

TCs are regarded as high threshold services for drug users interested in maintaining abstinence (Radimecký, 2007). In the absence of large-scale substitution programmes, as a result of the relatively low prevalence of heroin dependence in the Czech Republic (EMCDDA, 2012), TCs play an important role in the Czech drug treatment system and are allocated 9.2 % of the total drug policy budget (EUR 2 302 000) (Mravčík et al., 2011). However, the continuity of these services is not warranted, since TCs are subsidised on a year-to-year basis. Moreover, TCs are allowed to receive only up to 70 % of their budget from the state. Additional resources are generated from other sources, including fundraising activities, private donations and project grants.

TC residents in the Czech Republic are mainly methamphetamine users (71.6 %), while only 16.7 % report heroin as their primary drug (Mravčík et al., 2011). The majority of residents are injecting drug users (85.8 %). About 35 % of the residents have a dual diagnosis (Kalina, 2007), while adolescents and addicted women are other special needs groups that can be treated in some TCs but for whom some special TCs have been created. The average treatment duration is 185 days. Only 28.9 % complete treatment successfully and 44 % of all early dropouts leave the TC within 3 months. Several TCs welcome special target groups (e.g. adolescents, mothers with children, dually diagnosed individuals) and some have been dedicated to these populations.

TCs are run by multidisciplinary teams, including medical, psychological, social and pedagogical professions. A long tradition of specialised training and education is observed: addiction treatment has been incorporated as a specialisation in medical doctors' education since 1980, and since 2005 bachelors and masters in addictology (Faculty of Medicine, Charles University, Prague) can graduate as specialists for supporting and treating drug addicts. In addition to education and professional background, personal

experience and skills are also deemed important in TCs. Consequently, recovered ex-addicts are sometimes part of the staff, but it is rather unusual to have volunteers in the therapeutic team. Lifelong learning (e.g. participation in certified courses, internships in certified facilities, SUR psychotherapy training, regular supervision, conferences) is compulsory for any professional working in addiction treatment and should guarantee the quality of care.

TCs need to meet the quality standards of regular social services as they are controlled and subsidised by the Ministry of Labour and Social Affairs. As these standards are not specific to drug addiction services, the GCDPC has implemented its own certification standards for a range of addiction services (including TCs). The certification process includes general and specific standards for each type of drug service and consists of staff ethics, clients' rights and aims and guidelines for TCs and other services (see Chapter 4) (Adameček, 2007). These standards should not be regarded as evidence-based guidelines but are based on expert opinions. The ethical code approved by Czech TCs is based on the ethics code of the WFTC (Mravčík et al., 2011).

### Recent evolutions and future challenges

Recent trends and challenges regarding treatment in TCs include the differentiation towards special needs groups (e.g. dually diagnosed individuals, drug users coming from prison) and also changes in substance use patterns (e.g. illegal buprenorphine is now the main type of opioid dependence). Adequate psychiatric care and more individualised approaches have been introduced in TCs to meet these emerging needs. Second, the TC capacity is not in line with the demand for treatment, resulting in waiting lists in every TC and a great number of drug addicts being treated in non-certified TCs. Third, economic cutbacks have resulted in a reduction in the number of staff in TCs. As a consequence, staff working night shifts have been replaced with telephone availability during the night. Furthermore, TCs try to make extra money from farming and selling products and also by producing their own food (e.g. meat, eggs and vegetables). Finally, outreach activities are needed to reach drug addicts in prisons, as there is no treatment available in these settings (except counselling and motivational interventions), or Roma people, as they often have no contact with regular treatment services.

## 2.3. Summary of developments in European therapeutic communities

This chapter has shown how the so-called hierarchical concept TC originated in the late 1950s in the USA as an offspring of AA. The TC was introduced in Europe at the end of the 1960s and 1970s in the United Kingdom and was often used as an alternative for psychiatric treatment. It matured during the 1980s and spread all over Europe. Throughout the 1990s, its rise was interrupted because of problems with charismatic leadership in some TCs, a lack of evidence of their effectiveness from RCTs and a general tendency in society to cut down on residential care. The rollout of opioid substitution treatment (OST) a means of fighting the HIV epidemic in many cases was accompanied by a reduction in treated cases and treatment facilities in TCs.

Europe learnt much from the USA when setting up TCs. Synanon, Daytop and Phoenix House were either copied or adapted to national situations. During the early history of TCs, the US TC programmes were mostly built on strong self-help principles, including identification with older ex-addicts, whereas the TC movement in Europe from the beginning was set up by professionals with backgrounds in psychology, education or pedagogy. However, there were also national experiences and traditions that influenced developments. In the Czech Republic, for example, old TC traditions in alcohol treatment were the main source of national developments. In several countries, TCs set up by charismatic leaders developed into sect-like organisations, which led to legal steps being taken and a loss of public funding. TCs have historically been vulnerable to charismatic leadership, as illustrated in Spain, France and Sweden — this leadership can attract a number of drug users and resources for the TC programme, while at the same time exposing the programme to the risk of isolation and secrecy. Possible ways to prevent the exposure of TCs to charismatic leadership would be by arranging the financing of TC programmes by public authorities rather than by private resources, alongside the enforcement of quality control in TCs by external bodies.

As the concept of a standard TC matured, it was modified to address the needs of special populations. For instance, confrontations in encounter groups are not appropriate for psychotic residents and dually diagnosed individuals (Sacks et al., 2012), and modified TC approaches were developed for these populations in Belgium, the Czech Republic, Spain and Poland. The observation that not many women graduated from TCs led to the introduction of programmes for addicted

mothers and children whereby mothers follow TC treatment during the day and spend the rest of the time with their child(ren) in a TC annex (e.g. TC De Kiem in Belgium). Prison TCs began to be implemented in Europe (e.g. in the United Kingdom) and could present a notable niche for future modified TCs in other countries. Similar approaches to modified TCs are also available for homeless and adolescent substance abusers (De Leon, 1997).

For many years, the TC movement has been considered to be opposed to psychiatric or methadone maintenance services. Recently, TCs have involved themselves in integrative treatment systems (Broekaert and Vanderplasschen, 2003). This implies a focus on coordination and continuity of care to improve effectiveness and efficiency. It involves taking on board alternative approaches from outside the TC movement, in accordance with the needs of residents and their specific diagnoses. TCs work closely with the mental health care system; sometimes TCs even share premises with other therapeutic departments.



3



## CHAPTER 3

# Review of the effectiveness of therapeutic communities

This chapter provides an overview of the evidence on the effectiveness of TCs detailed in the published international literature. The first part (section 3.1) summarises the main findings from systematic reviews conducted to date; the following sections provide a new systematic review and the results of TC outcome research focused on (i) international randomised and non-randomised controlled studies and (ii) European observational research.

### 3.1. Findings from available reviews

Over the last decade, four independent reviews (Lees et al., 2004; Smith et al., 2006; De Leon, 2010; Malivert et al., 2012) have been published in the English-language literature on the effectiveness of drug-free TCs. The conclusions from these reviews are quite divergent, which can be partly explained by the different scope, objectives, selection criteria and analytical methods applied in these studies. Few publications were included in all four reviews. For this reason it was found useful for this publication to review all existing TC studies meeting the inclusion criteria and which follow the definition provided in section 1.2.

The first systematic review and meta-analysis on the effectiveness of TCs was conducted by Lees, Manning and Rawlings (2004) in the United Kingdom, and was based on 29 (21 non-randomised and eight randomised controlled trials). Given the long tradition in the United Kingdom of democratic TCs for individuals with personality disorders, the authors did not restrict their search criteria to 'concept' TCs, resulting in the inclusion of studies with a substantially heterogeneous population. Overall, this meta-analysis demonstrated a strong positive effect of TC treatment compared with a range of control interventions [summary log odds ratio =  $-0.512$  (95 % CI  $-0.598$  to  $-0.426$ )] (Lees et al., 2004). This global outcome measure was a summary score, based on various criteria. If available, a conservative indicator (e.g. reconviction rate) was used. Concept TCs for the treatment of addictions appeared to

be more effective than democratic TCs, although this finding may have been moderated by the fact that studies of democratic TCs were generally much older (15 years or more) and addressed more severely disordered persons.

The often-cited Cochrane review by Smith, Gates and Foxcroft (2006) focused exclusively on concept, drug-free TCs for the treatment of addictions, based on the results of seven RCTs. TC treatment was compared with various types of control conditions, including day treatment, community residence and TCs with short or long programmes. The outcomes studied included treatment completion, changes in substance use, and, if reported in the original papers, other outcomes (e.g. employment, criminal involvement). The authors concluded that there was little evidence that TCs could offer significant benefits in comparison with other types of residential treatment, or that one type of TC was better than another in terms of drug use-related outcomes and retention in treatment. The review and meta-analyses, however, are based on a limited number of studies, some of which have notable methodological limitations. For example, the randomisation process in a number of included trials was characterised by substantial attrition, and treatment dropout was also often observed. Consequently, Smith and colleagues (2006) have recommended setting up more clinical trials, as well as using pragmatic study designs that retain all subjects in the analyses in order to better document the effectiveness of TCs.

De Leon (2010) has challenged the assertion that, because of the insufficient RCT-based research on the effectiveness of TCs, the effectiveness of this treatment modality has not been 'proven', and conducted a non-exhaustive, but comprehensive, review of the North American literature on TCs, sourcing evidence from the following: (1) field effectiveness (observational) studies employing a longitudinal, naturalistic design that follow TC residents during and after treatment — some of these studies were large-scale studies, evaluating the effectiveness of a range of treatment modalities, including TCs [e.g. Treatment Outcome Prospective Study (TOPS),

Drug Abuse Treatment Outcome Studies, (DATOS)] , while others were 'case' studies exploring the effectiveness of a single TC programme (e.g. Phoenix House); (2) controlled studies of TCs or modified TCs, evaluating treatment effectiveness in comparative terms, relative to another treatment condition or no treatment in the context of a controlled (non-)randomised experiment; (3) meta-analyses using statistical techniques to assess the effectiveness of TCs relative to a comparison (no) treatment condition, based on combining results from different studies; and (4) economic analyses looking at the cost and economic evaluation of TCs.

The evidence from these sources was in support of the effectiveness of TCs. Multiple field effectiveness studies have demonstrated the relationship between retention in TC treatment and positive treatment outcome. An analysis of eight controlled studies, of which seven were RCTs, demonstrated that TC treatment outcome was significantly better in terms of drug use, legal involvement and employment outcomes than a non-TC control condition. Five published economic (cost–benefit) evaluations have demonstrated high TC treatment delivery costs, which were, however, compensated for by the significant savings to society — in particular, the reduction in the costs of criminal proceedings as a result of associated criminal activity and gains from participants being restored to employment. De Leon (2010) concludes that there is substantial evidence in support of TC treatment. He refers to the strength of the relation between treatment completion and positive outcome, treatment dosage and post-treatment success and the differential effectiveness of TCs compared with other treatment modalities (especially for clients with severe problems). Treatment outcomes might also be affected by self-selection (i.e. motivation for treatment) and self-matching (i.e. clients' choice for a specific treatment) processes (De Leon, 2010).

Most recently, Malivert et al. (2012) conducted a systematic review — comprising 12 studies — with a focus on TC treatment process and outcome. Studies of prison TCs were excluded from this review. Reported treatment completion rates varied widely across the studies (from 9 % to 56 %), with programme cessation occurring most often during the first 15–30 days of treatment. All reviewed studies showed a decrease in substance use during the follow-up periods, although between 21 % and 100 % of the study subjects had used substances or met criteria for relapse during the follow-up periods. Between 20 % and 33 % of the study populations re-entered treatment during the studies' follow-up periods. Given the large differences in treatment duration and length of follow-up period,

substance use outcomes were difficult to compare across studies. Methodological limitations in the original studies did not allow differentiation between persons who relapsed to their primary problem substance and those with a new addiction, or between persons who used occasionally or moderately and heavy users, thus preventing this review from reaching a conclusion on the long-term benefits of TC treatment. TC treatment completion and retention in treatment were identified as the most robust predictors of abstinence at follow-up (Malivert et al., 2012).

To date, research endeavour has consistently been devoted to establishing the effectiveness of TCs as a treatment for addictions. However, the available evidence base has yet to be strengthened, by properly designed and conducted controlled research. Two meta-analyses demonstrated that, although TCs for addictions can be considered to be more effective than TCs for personality disorders (Lees et al., 2004), the evidence base is limited for the effectiveness of TCs compared with other forms of residential treatment (Smith et al., 2006). Malivert and colleagues (2012) observed considerable reductions in substance use during and after TC treatment but also substantial relapse rates (around 50 %) over extended follow-up periods. The only finding that all four reviews confirm is that length of stay in treatment is associated with better outcomes in terms of drug use and recidivism, and the longer that residents are retained in TC treatment, the more enduring the observed abstinence following TC treatment (Malivert et al., 2012).

In Europe to date, no controlled studies of drug-free TCs have been conducted, and findings from observational studies have not been systematically reviewed. The RCT design is considered the 'gold standard' for the generation of scientific level 1 evidence about the efficacy of treatments (Glasziou et al., 2007). However, applying RCT or quasi-experimental research designs (e.g. interrupted time series study, historically controlled study) appears to be problematic for the evaluation of complex and integrated interventions such as the TC (Gossop, 2012). Observational studies can be particularly helpful for treatment evaluation in naturalistic settings, where ethical, pragmatic or scientific considerations may prevent researchers from setting up controlled studies.

### 3.2. The present review

This review builds on earlier reviews of the literature by bringing into focus and systematically reviewing international randomised and non-randomised

controlled studies (referred to as ‘controlled’ research henceforth in this publication) and European studies using observational designs to evaluate the effectiveness of TCs. Although a number of observational studies have been set up in North America and other parts of the world, for pragmatic reasons this study includes only observational research in the EU and Turkey, Norway and Switzerland.

## Study identification

The following databases were searched for eligible records published up to 31 December 2011: ISI Web of Science (WoS), PubMed and DrugScope. There were no language restrictions (?). Search strategies were developed for each database, based on the search strategy developed for ISI Web of Knowledge, but revised accordingly to take into account differences in vocabulary and syntax rules. The following terms or combinations of these terms were used in the search strategy: ‘therapeutic communit\*’ AND ‘drug\* or addict\* or dependen\* or substance use’ AND ‘outcome\* or evaluation or follow-up or effectiveness’. In addition, the reference lists of retrieved studies and of available reviews were checked for relevant studies, as well as screening the index of the *International Journal of Therapeutic Communities*, a specialised peer-reviewed journal on TCs.

In addition to the database search, abstracts of conferences of the EFTC, the WFTC and the European Working Group on Drugs Oriented Research (EWODOR) and grey literature were scanned for relevant (un)published studies, and *metaRegister* of Controlled Trials, Clinical Trials and Trials Central registers were searched to ensure that no ongoing trials were neglected. One RCT that is under way was identified [Oxfordshire Complex Needs Service (OCNS, Oxford, UK)], but as it concerned a day treatment TC facility for persons with personality disorders (not in combination with a drug addiction) this study was not included. Where publications, particularly older ones, could not be tracked through the Ghent University online library system, the study authors were contacted and asked to provide a copy of their manuscript.

Finally, TC experts in various countries, including George De Leon (USA), Rowdy Yates (United Kingdom), Edle Ravndal (Norway), Albert Sabates (Spain), Kamil Kalina (Czech Republic), Andrea Ascari (Italy) and Masza Charmast (Poland), and the EMCDDA’s network of NFPs were contacted to identify additional (un)published or

ongoing studies on the effectiveness of addiction TCs. Those contacts yielded two additional studies: one from the Czech Republic and one from Poland. At the time of writing, the latter study is at the conceptualisation stage. Preliminary and unpublished data, which will be presented separately in this review, are available for the Czech study (Šefránek, 2012).

## Inclusion and exclusion criteria

Eligible studies reported:

Intervention: drug-free TC for the treatment of addiction (also referred to as ‘concept TCs’, see Chapter 1 for definition).

Target population: drug- (and alcohol-) dependent users — studies including persons with co-morbid psychiatric disorders were eligible for inclusion if all study participants had a drug addiction.

At least one of the following outcomes was reported: retention in treatment; treatment completion; dropout; substance use; employment status; criminal involvement; health and well-being; family relations; quality of life; mortality.

Type of studies:

- Controlled studies: RCT and non-randomised (quasi-experimental) studies (QES) that have evaluated post-treatment TC outcomes relative to a control condition; no country restriction was applied for selecting these types of studies.
- Observational studies: single- or multi-programme studies that have examined post-treatment TC outcomes; studies were restricted to those conducted in countries of the EU plus Norway, Turkey and Switzerland.

Non-English-language publications were considered for inclusion. Available systematic reviews and meta-analyses were not included, but all studies selected for these reviews were screened based on the aforementioned inclusion criteria. Studies were excluded if they did not distinguish TC treatment from other residential treatments for addiction.

## Study selection and data extraction

The abstracts retrieved in the literature searches described above were screened by two reviewers for potential relevance; full text papers for the selected abstracts were

(?) The search strings were in English only; national experts and authors were contacted for access to non-English-language publications.

obtained and further screened by at least two reviewers. The following information was extracted, where available, from each paper and presented in Table 3.1 (controlled studies) and Table 3.4 (observational studies):

- study features: author(s), year of publication; geographical area (country/state/region); recruitment site(s); study design; time to follow-up; in addition, for cohort studies, information on numbers/proportion of participants followed up and lost to follow-up was collected;
- sample characteristics: sample size; problem drug/alcohol use; inclusion criteria;
- treatment characteristics: type of treatment studied; treatment setting; duration of planned treatment programme;
- outcomes studied and study findings: retention in treatment, completion of planned treatment programme, dropout rate; substance use (illicit drugs and alcohol); criminal involvement; employment; other outcomes (e.g. physical/mental health, housing, quality of life).

The results of the review are presented in two parts, each describing the findings of (1) controlled studies irrespective of the country in which they were conducted and (2) observational studies conducted in Europe. Meta-analyses were not considered appropriate for this review owing to the heterogeneity of methodology and the broad range of outcomes and outcome measures used across the original studies. The review compares

the effectiveness of TCs with that of other treatment modalities/conditions studied (based on controlled research) on a range of outcomes (as detailed above) and focuses on the effectiveness of TC treatment with regard to a range of outcomes (based on controlled and observational research).

## Results

A total of 185 abstracts and 73 full text papers were reviewed, yielding 49 papers, of which 28 report controlled studies and 21 report observational studies on the effectiveness of TC treatment for addiction (Figure 3.1).

### 3.2.1 Controlled studies

A total of 45 potentially eligible papers reporting controlled studies were identified from the multiple sources described above. After reading the full texts of 45 articles, 28 met the inclusion criteria and were retained in this review. Table 3.1 provides a list of the included papers, as well as indicating which of these publications were included in previous reviews ( $n = 14$ ) and which were not ( $n = 14$ ). Recent studies (published since 2001) have not been included in any of the aforementioned reviews (see section 3.1). Consequently, more than a quarter of all controlled studies were not analysed in any of the reviews conducted to date.

FIGURE 3.1

Flow chart of the search process and number of records identified, retained and excluded at each phase

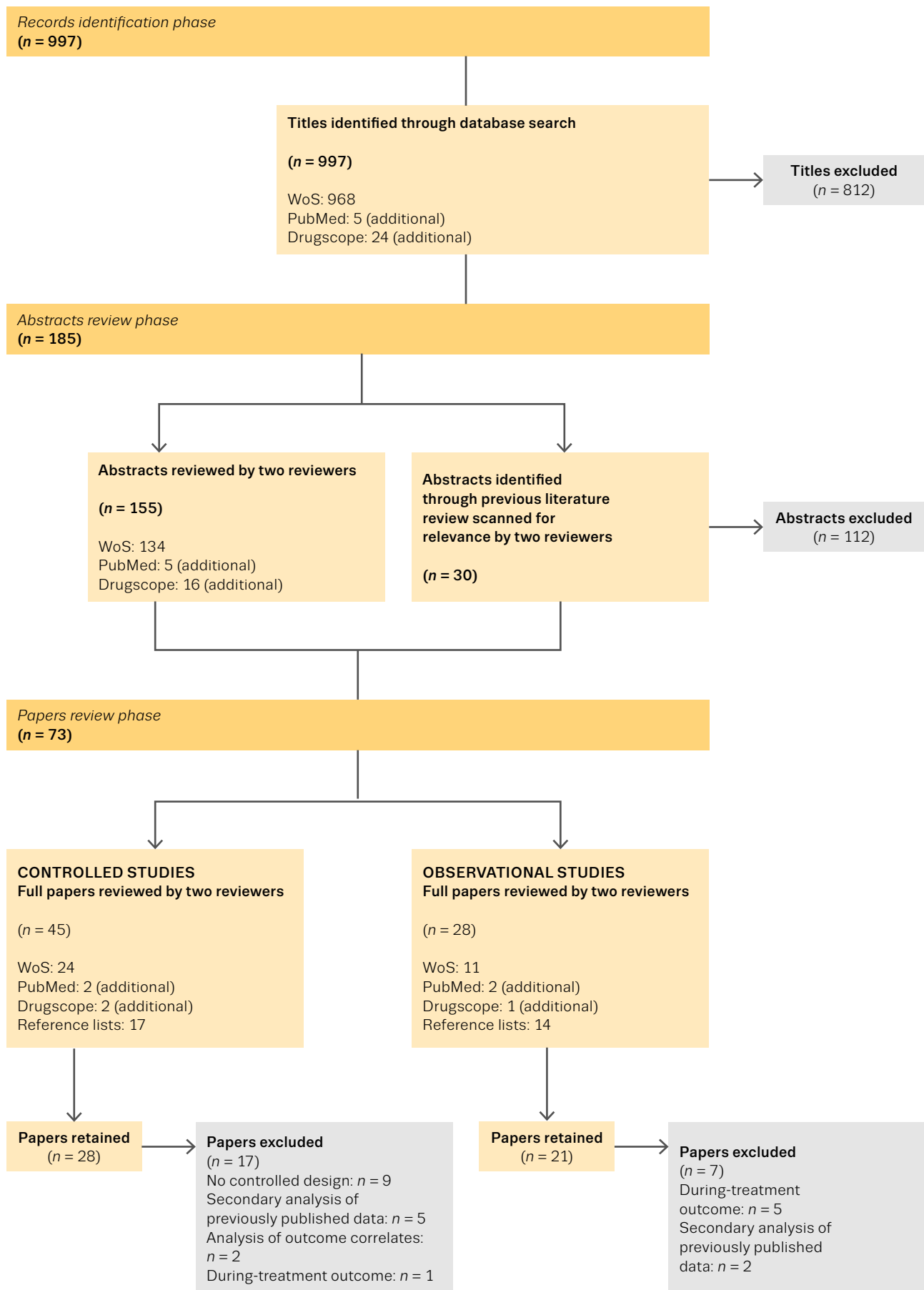


TABLE 3.1

**Controlled studies included in this review (n = 28), presented in chronological order (from most recent to oldest), geographical area and indication of inclusion in previous reviews**

Full study reference	Country	Malivert et al. (2012)	De Leon (2010)	Smith et al. (2006)	Lees et al. (2004)
1. Sacks, S., Chaple, M., Sacks, J. Y., McKendrick, K. and Cleland, M. (2012), 'Randomized trial of a re-entry modified therapeutic community for offenders with co-occurring disorders: crime outcomes', <i>Journal of Substance Abuse Treatment</i> 42, pp. 247–259.	USA				
2. Zhang, S. X., Roberts, R. E. L. and McCollister, K. E. (2011), 'Therapeutic Community in a California prison: treatment outcomes after 5 years', <i>Crime and Delinquency</i> 57, pp. 82–101.	USA				
3. Messina, N., Grella, C. E., Cartier, J. and Torres, S. (2010), 'A randomized experimental study of gender-responsive substance abuse treatment for women in prison', <i>Journal of Substance Abuse Treatment</i> 38, pp. 97–107.	USA				
4. Welsh, W. N. (2007), 'A multisite evaluation of prison-based therapeutic community drug treatment', <i>Criminal Justice and Behavior</i> 34, pp. 1481–1498.	USA				
5. Sullivan, C. J., McKendrick, K., Sacks, S. and Banks, S. (2007), 'Modified therapeutic community treatment for offenders with MICA disorders: substance use outcomes', <i>American Journal of Drug and Alcohol Abuse</i> 33, pp. 823–832.	USA				
6. Morral, A. R., McCaffrey, D. F. and Ridgeway, G. (2004), 'Effectiveness of community-based treatment for substance-abusing adolescents: 12-month outcomes of youths entering Phoenix Academy or alternative probation dispositions', <i>Psychology of Addictive Behaviors</i> 18, pp. 257–268.	USA				
7. Sacks, S., Sacks, J. Y., McKendrick, K., Banks, S. and Stommel, J. (2004), 'Modified TC for MICA offenders: crime outcomes', <i>Behavioral Sciences and the Law</i> 22, pp. 477–501.	USA		•	•	
8. Inciardi, J. A., Martin, S. S. and Butzin, C. A. (2004), 'Five-year outcomes of therapeutic community treatment of drug-involved offenders after release from prison', <i>Crime and Delinquency</i> 50, pp. 88–107.	USA				
9. Prendergast, M. L., Hall, E. A., Wexler, H. K., Melnick, G. and Cao, Y. (2004), 'Amity prison-based therapeutic community: 5-year outcomes', <i>Prison Journal</i> 84, pp. 36–60.	USA				
10. Prendergast, M. L., Hall, E. A. and Wexler, H. K. (2003), 'Multiple measures of outcome in assessing a prison-based drug treatment program', <i>Journal of Offender Rehabilitation</i> 37, pp. 65–94.	USA				
11. Greenwood, G. L., Woods, W. J., Guydish, J. and Bein, E. (2001), 'Relapse outcomes in a randomized trial of residential and day drug abuse treatment', <i>Journal of Substance Abuse Treatment</i> 20, pp. 15–23.	USA	•			
12. De Leon, G., Sacks, S., Staines, G. and McKendrick, K. (2000), 'Modified therapeutic community for homeless mentally ill chemical abusers: treatment outcomes', <i>American Journal of Drug and Alcohol Abuse</i> 26, pp. 461–480.	USA				
13. French, M. T., Sacks, S., De Leon, G., Staines, G. and McKendrick, K. (1999), 'Modified therapeutic community for mentally ill chemical abusers: outcomes and costs', <i>Evaluation and the Health Professions</i> 22, pp. 60–85.	USA				
14. Wexler, H. K., De Leon, G., Thomas, G., Kressel, D. and Peters, J. (1999), 'The Amity prison TC evaluation', <i>Criminal Justice and Behavior</i> 26, pp. 147–167.	USA		•	•	
15. Guydish, J., Sorensen, J. L., Chan, M., Werdegard, D., Bostrom, A. and Acampora, A. (1999), 'A randomized trial comparing day and residential drug abuse treatment: 18-month outcomes', <i>Journal of Consulting and Clinical Psychology</i> 67, pp. 428–434.	USA	•	•		
16. Nemes, S., Wish, E. D. and Messina, N. (1999), 'Comparing the impact of standard and abbreviated treatment in a therapeutic community. Findings from the district of Columbia treatment initiative experiment', <i>Journal of Substance Abuse Treatment</i> 17, pp. 339–347.	USA	•	•	•	
17. Martin, S., Butzin, C. A., Saum, C. A. and Inciardi, J. A. (1999), 'Three year outcomes of therapeutic community treatment for drug-involved offenders in Delaware', <i>Prison Journal</i> 79, pp. 291–320.	USA		•		
18. Nuttbrock, L. A., Rahav, M., Rivera, J. J., Ng-Mak, D. S. and Link, B. G. (1998), 'Outcomes of homeless mentally ill chemical abusers in community residences and a therapeutic community', <i>Psychiatric Services</i> 49, pp. 68–76.	USA			•	

Full study reference	Country	Malivert et al. (2012)	De Leon (2010)	Smith et al. (2006)	Lees et al. (2004)
19. Guydish, J., Werdegart, D., Clark, W., Sorensen, J. L. and Acampora, A. (1998), 'Drug abuse day treatment: a randomised clinical trial comparing day and residential treatment programs', <i>Journal of Consulting and Clinical Psychology</i> 66, pp. 280–289.	USA			•	
20. McCusker, J., Bigelow, C., Frost, R., Garfield, F., Hindin, R., Vickers-Lahti, M. et al. (1997a), 'The effects of planned duration of residential drug abuse treatment on recovery and HIV risk behaviour', <i>American Journal of Public Health</i> 87, pp. 1637–1644.	USA		•	•	
21. Lockwood, D., Inciardi, J. A., Butzin, C. A. and Hooper, R. M. (1997), 'The therapeutic community continuum in corrections', in: De Leon, G. (ed.), <i>Community as method. Therapeutic communities for special populations and special settings</i> , Praeger, Westport, CT, pp. 87–96.	USA				•
22. Hartmann, D. J., Wolk, J. L., Johnston, J. S. and Colyer, C. J. (1997), 'Recidivism and substance abuse outcomes in a prison-based therapeutic community', <i>Federal Probation</i> 61, p. 18–25.	USA				
23. Nielsen, A. L., Scarpitti, F. R. and Inciardi, J. A. (1996), 'Integrating the therapeutic community and work release for drug-involved offenders: the Crest program', <i>Journal of Substance Abuse Treatment</i> 13, pp. 349–358.	USA				•
24. McCusker, J., Stoddard, A., Frost, R. and Zorn, M. (1996), 'Planned versus actual duration of drug abuse treatment. Reconciling observational and experimental evidence', <i>Journal of Nervous and Mental Disease</i> 184, pp. 482–489.	USA	•			
25. McCusker, J., Vickers-Lahti, M., Stoddard, A., Hindin, R., Bigelow, C., Zorn, M., et al. (1995), 'The effectiveness of alternative planned durations of residential drug abuse treatment', <i>American Journal of Public Health</i> 85, pp. 1426–1429.	USA			•	
26. Bale, R. N., Zarcone, V.P., Van Stone, W. W., Kuldau, J. M., Engelsing, T. M. J. and Elashoff, R. M. (1984), 'Three therapeutic communities — a prospective controlled study of narcotic addiction treatment — process and 2 year follow-up results', <i>Archives of General Psychiatry</i> 41, pp. 185–191.	USA				
27. Coombs, R. H. (1981), 'Back on the streets: therapeutic communities' impact upon drug users', <i>American Journal of Drug and Alcohol Abuse</i> 8, pp. 185–201.	USA				
28. Bale, R. N., Van Stone, W. W., Kuldau J. M., Engelsing, T. M., Elashoff, R. M. and Zarcone, V. P. (1980), 'Therapeutic communities vs. methadone-maintenance — prospective controlled study of narcotic addiction treatment — design and one year follow-up', <i>Archives of General Psychiatry</i> 37, pp. 179–193.	USA		•		

Seventeen articles were excluded for the following reasons: the study had not used a controlled design ( $n = 9$ ); report of secondary analyses of previously published data ( $n = 5$ ); analysis of outcome correlates ( $n = 2$ ); and only during-treatment outcomes reported ( $n = 1$ ). Full references to all studies that were excluded in this phase are listed in Annex C alongside the country where recruitment took place, and the reason for exclusion from this review.

The 28 included papers (Table 3.2) were based on a total of 16 unique studies (papers derived from one study were accessed and included when they reported different outcomes and/or follow-up periods) [e.g. the Delaware studies (Lockwood et al., 1997; Martin et al., 1999; Inciardi et al., 2004) and the Amity prison TC studies (Wexler et al., 1999; Prendergast et al., 2003; Prendergast et al., 2004)].



TABLE 3.2

Type of comparison group studied (refer to study codes)

Type of comparison group	Controlled studies				
	Community or prison TC?	Study	Study code	Substance use outcome	Criminal offences
Between-group difference on outcomes of TC treatment provided in different setting	Prison TC	Messina et al. (2010)	A	•	
		Martin et al. (1999)	B	•	•
		Lockwood et al. (1997)	C	•	•
	Community TC	Greenwood et al. (2001)	D	•	
		Guydish et al. (1998)	E		
		Guydish et al. (1999)	F		
		Nemes et al. (1999)	G	•	•
		De Leon et al. (2000)	H	•	•
		McCusker et al. (1997a)	I	•	•
		McCusker et al. (1995)	J		
		McCusker et al. (1996)	K	•	
		French et al. (1999)	L	•	•
		Coombs (1981)	M	•	
TC treatment with no treatment	Prison TC	Zhang et al. (2011)	N		•
		Morral et al. (2004)	O	•	•
		Inciardi et al. (2004)	P	•	•
		Nielsen et al. (1996)	Q	•	•
		Prendergast et al. (2004)	R	•	•
		Prendergast et al. (2003)	S	•	•
		Wexler et al. (1999)	T		•
		Hartmann et al. (1997)	U	•	•
	Community TC	Nuttbrock et al. (1998)	V	•	
TC treatment with usual care	Prison TC	Sacks et al. (2012)	W		•
		Welsh (2007)	X	•	•
		Sullivan et al. (2007)	Y	•	
		Sacks et al. (2004a)	Z		•
	Community TC	Bale et al. (1984)	A1	•	•
		Bale et al. (1980)	B1	•	•

The oldest controlled studies date from the beginning of the 1980s (M, A1, B1) and the bulk of studies were performed or published in the 1990s. All controlled studies were performed in the USA. Despite a growing research tradition in European, Australian and South American TCs, only observational studies, and no controlled research, have been set up and carried out on these continents. Retrieved (but excluded) non-US studies had applied (retrospective) cohort study designs (e.g. Toumbourou et al., 1998). Since the publication of the Smith et al. (2006) review on TC effectiveness, two randomised and three non-randomised controlled studies have been published, all carried out in TCs in correctional settings.

Thirteen papers (studies A to M inclusive) reported between-group differences in the outcomes of TC treatment provided in different settings [(e.g. community TC vs. day TC, e.g. study E) or of TCs of different intensity or length, (e.g. study J)]. In the latter case, the

longer or most comprehensive TC programme was regarded as the experimental condition. Nine reports compared TC treatment with no treatment (studies N to V inclusive). Six comparisons were identified of TC treatment with some form of usual care (e.g. case management, standard treatment) (studies W to B1 inclusive). Some comparisons reported in the literature (e.g. study B) included multiple control conditions, although significant between-group differences could typically be identified when comparing the most intensive with the least intensive treatment condition.

As shown in Table 3.2, more controlled research that was eligible for inclusion in this review has studied prison-based TC treatment outcomes than community TC treatment outcomes. While a substantial number of drug users may enter community TC treatment under legal pressure, TC treatment in prisons has to be regarded in a rather different context given the compulsory custody and conditional release term and



privileges. For this reason, and where available evidence would allow it, results are presented separately for community and prison settings.

### Retention in treatment and treatment completion

Where study participant recruitment has occurred at the start of TC treatment rather than at the point of treatment departure (treatment completion or dropout), studies have been in the position to assess retention in treatment — four trials reported retention in treatment, using measures of ‘days in treatment’ (D, E) or ‘6-month retention in treatment’ (E) and ‘12-month retention in treatment’ (F, V). In addition to treatment retention, completion of the planned treatment programme was evaluated in four reports (G, I, K, M), all of which yielded non-significant between-group differences when comparing standard (12-month programme) with abbreviated 3-month (K) or 6-month (G) programme TCs.

According to the available data, TC participants fare worse than controls with regard to treatment retention and completion of treatment. Substantial dropout has been observed in most long-term TC programmes, especially in the early phases of treatment (study F). Studies that have compared long- and short-term TC programmes usually found lower completion rates in the longer programmes (I, V).

### Substance use

In the substance use outcome domain, across the articles included in this review, the main interest was in three measures: (1) self-reported primary drug use, operationalised in various ways from ‘complete abstinence’ towards ‘reduced drug use at follow-up’; (2) relapse to drug use; and (3) time to relapse.

#### *Prison TCs*

Considering prison TCs only, of the 11 papers that reported the substance use treatment outcome, the results of eight (B, C, O, P, Q, S, U, Y) suggested that TC subjects fare significantly better at follow-up, and in the other three no significant between-group differences were reported at 6-, 12-, 24- (A, X) and 60-month (R) follow-up in this outcome domain.

Five trials (A, O, R, X, Y) measured changes in drug (and alcohol) use, employing some form of self-report, with the exception of Study X, where urine drug screen results were used to measure drug use outcome.

Abstinence was a measure of choice in four of the trials (B, C, P, U), and relapse or time to relapse was measured and reported by one (Q) and two papers (S, Y), respectively. Reported abstinence following prison TC treatment was consistently high — 85.4 % and 87 % at 5- and 6-month follow-up, respectively (C, U) — but treatment gains seemed to have diminished by 18 months after treatment was completed, with relapse reported at 51.7–69 % (B, Q).

#### *Community TCs*

Of 11 papers reporting outcomes in this domain, the findings of eight (D, G, H, K, M, V, A1, B1) suggested that TC participants had a significantly better outcome in at least one outcome measure, or at one time point, compared with control conditions. Across the studies, substance use was measured as self-reported reduction in drug use (G, H, L, B1) or using a urine drug screen (V); abstinence (D, M, A1); relapse (J, K, M); or time to relapse (I).

With regard to short-term as well as longer-term outcome, community residential TC participants were reported to have fared better than control groups at the 6-month follow-up (D, I, J), and the gains appeared to have been maintained as evidenced by measurement at the 12-, 18- and 24-month points. These superior results for the TC groups reached statistical significance in half or more of the reports at each time point [6-month follow-up (D, K); 12-month follow-up (H, L, M, V, B1); 18-month follow-up (G); and 24-month follow-up (H, A1)].

### Criminal offences

#### *Prison TCs*

With regard to the criminal offence outcomes of prison TCs, of the 14 papers that assessed this outcome domain, 11 (B, C, P, Q, R, S, T, U, W, X, Z) reported that at follow-up (5–60 months after release), prison TC participants fared significantly better than incarcerated drug users who participated in some form of usual prison drug treatment or received no treatment during incarceration. Three papers (A, N, O) reported no significant between-group differences at follow-up (6 and 12 months) in that domain.

The majority of studies found a positive impact of TC treatment on diverse criminal offence outcomes, including recidivism, re-arrest and reincarceration. Reincarceration rates 12 to 18 months after release

were between 30 % and 55 % in most studies, although Sacks and colleagues reported lower rates [modified TC 19 % vs. parole supervision 38 % (W); prison modified TC 9 % vs. standard prison treatment 33 % (Z)]. Longer-term follow-up of prison TC participants indicated a reincarceration rate of 76 % vs. 83 % in the control group, at five-year post release follow-up (R).

Time to re-arrest (days to first illegal activity after release) was a reported outcome in five papers (A, G, R, S, W). Although time to event was significantly longer in the TC group than in the control group in two reports [time to re-arrest — standard TC 9.4 months vs. abbreviated TC 6.9 months (G); days to first illegal activity — prison TC 138 days vs. no treatment 71 days (S)], another two reported significant between-group differences in favour of the control conditions studied [days to reincarceration — modified TC 161 vs. parole supervision 168 (W); days to reincarceration — prison TC 634 vs. no treatment 809 (R)], and one study did not identify significant between-group differences [return to custody — prison modified TC 31 % vs. standard prison TC 45 % (A)].

#### *Community TCs*

The criminal offence outcome domain has been considerably less well evaluated among community TC participants, with six papers reporting criminal activity outcome (G, H, I, L, A1, B1). The findings in five papers (G, H, L, A1, B1) suggested that TC participants had a significantly better outcome on at least one outcome measure or at one time point compared with control conditions [reduced self-reported criminal activity or criminal problems (H, L); re-arrest (G, B1); conviction (A1, B1)].

#### **Predictors of post-treatment substance use and criminal offences**

Although correlates of treatment outcome were not in the focus of the present review, it should be noted that

lower rates of relapse to drug use or criminal activity were associated with longer treatment exposure (H, K, M, Q, A1), participation in aftercare (N, P, T), post-treatment employment (X) and older age (P, R). Completing the planned TC treatment programme was associated with better treatment outcome in those who completed the TC programme compared with dropouts (R, T). Dropout during and relapse after treatment was predicted in at least two studies by the severity of substance use at baseline (P, V).

#### **Employment and other outcomes**

A number of controlled studies have explored outcomes beyond substance use and criminal activity. All of the seven studies that reported between-group comparisons in the domain of employment (G, H, I, R, X, A1, B1) detected a significantly better employment situation in TC participants compared with recipients of other treatment modalities (e.g. study X) or no treatment while on a waiting list (e.g. study R).

Of the seven studies that explored other outcomes [family functioning (study A); physical and mental health (studies E, F, L, O, R); mortality (study A1)], only Messina et al. (study A) and Prendergast et al. (study R) reported no statistically significant between-group differences at follow-up. In the remaining studies, TC participants were consistently reported to have fared significantly better in terms of social functioning, health and survival at follow-up compared with control groups.

#### **3.2.2. Observational studies**

A total of 28 potentially eligible papers reporting observational studies conducted in Europe were identified, of which 21 were retained as meeting the inclusion criteria of this review (Table 3.3).

TABLE 3.3

**Observational studies included in this review (n = 21), presented in chronological order (from most recent to oldest) and geographical area**

Full study reference	Country
1. Lopez-Goni, J., Fernández-Montalvo, J., Menéndez, J.C., Yudego, F., García, A. and Esarte, S. (2011), 'Employment integration after therapeutic community treatment: a case study from Spain', <i>International Journal of Social Welfare</i> 20, pp. 292–297.	Spain
2. Lopez-Fernandez, O., Ferrer-Perez, X., Lafarga-Lebey, S., Honrubia-Serrano, M. L. and Tudela-Mari, M. (2011), 'Follow-up of alcohol and/or cocaine dependents after their discharge from a Therapeutic Community: a pilot study', <i>Adicciones</i> 23, pp. 289–298.	Spain
3. Lopez-Goni, J., Fernández-Montalvo, J., Menéndez, J. C., Yudego, F., García, A. and Esarte, S. (2010), 'Group and individual change in the treatment of drug addictions: a follow-up study in therapeutic communities', <i>Spanish Journal of Psychology</i> 13, pp. 906–913.	Spain
4. Salamina, G., Diecidue, R., Vigna-Taglianti, F., Jarre, P., Schifano, P., Bargagli, A., Davoli, M. et al. (2010), 'Effectiveness of therapies for heroin addiction in retaining patients in treatment: results from the VEdeTTE Study', <i>Substance Use and Misuse</i> 45, pp. 2076–2092.	Italy
5. Davoli, M., Bargagli, A., Perucci, C., Schifano, P., Belleudi, V., Hickman, M. et al. (2007), 'Risk of fatal overdose during and after specialist drug treatment: the VEdeTTE study, a national multi-site prospective cohort study', <i>Addiction</i> 102, pp. 1954–1959.	Italy
6. Fernandez-Montalvo, J., Lopez-Goni, J., Illescas, C., Landa, N. and Lorea, I. (2008), 'Evaluation of a therapeutic community treatment program: a long-term follow-up study in Spain', <i>Substance Use and Misuse</i> 43, pp. 1362–1377.	Spain
7. Quercioli, C., Fini, P., Morgagni, S., Frola, C., Carraro, D., Carioli, R., Spinella, V. et al. (2007), 'Effectiveness of drug addicted therapeutic community: long term follow-up', <i>European Journal of Public Health</i> 17, pp. 116–117.	Italy
8. Quercioli, C., Fini, P., Morgagni, S., Frola, C., Carraro, D., Carioli, R., Spinella, V., Longo, L. et al. (2006), 'Effectiveness evaluation of drug addicted therapeutic community', <i>European Journal of Public Health</i> 16, p. 126.	Italy
9. Berg, J. E. (2003), 'Mortality and return to work of drug abusers form therapeutic community treatment 3 years after entry', <i>Primary Care Companion Journal of Clinical Psychiatry</i> 5, pp. 164–167.	Norway
10. Fernandez-Hermida, J. R., Secades-Villa, R., Fernandez-Ludena, J. J. and Marina-Gonzalez, P. A. (2002), 'Effectiveness of a therapeutic community treatment in Spain: a long-term follow-up study', <i>European Addiction Research</i> 8, pp. 22–29.	Spain
11. Keen, J., Oliver, P., Rowse, G. and Mathers, N. (2001), 'Residential rehabilitation for drug users: a review of 13 months' intake to a therapeutic community', <i>Family Practice</i> 18, pp. 545–548.	UK
12. Fredersdorf, F. (2000), 'Synanon in Germany: an example of a residential self-help organization for drug dependent individuals', <i>International Journal of Self Help and Self Care</i> 1, pp. 131–143.	Germany
13. Van de Velde, J. C., Schaap, G. E. and Land, H. (1998), 'Follow-up at a Dutch addiction hospital and effectiveness of therapeutic community treatment', <i>Substance Use and Misuse</i> 33, pp. 1611–1627.	Netherlands
14. Ravndal, E. and Vaglum, P. (1998), 'Psychopathology, treatment completion and 5 years outcome: a prospective study of drug abusers', <i>Journal of Substance Abuse Treatment</i> 15, pp. 135–142.	Norway
15. Ravndal, E. and Vaglum, P. (1992), 'HIV positive drug abusers in a hierarchical therapeutic community. A prospective study', <i>Nordic Journal of Psychiatry</i> 46, pp. 307–314.	Norway
16. Kooyman, M. (1992), <i>The Therapeutic Community for addicts: intimacy, parent involvement and treatment outcome</i> , Universiteitsdrukkerij Erasmusuniversiteit, Rotterdam.	Netherlands
17. Uchtenhagen, A. and Zimmer-Höfler, D. (1987), 'Psychosocial development following therapeutic and legal interventions in opiate dependence. A Swiss national study', <i>European Journal of Psychology of Education</i> 2, pp. 443–458.	Switzerland
18. Wilson, S. and Mandelbrote, B. (1985), 'Reconviction rates of drug dependent patients treated in a residential therapeutic community. 10 year follow-up', <i>British Medical Journal</i> 291(6488), p. 105.	UK
19. Wilson, S. and Mandelbrote, B. (1978a), 'Relationship between duration of treatment in a therapeutic community for drug abusers and subsequent criminality', <i>British Journal of Psychiatry</i> 132, pp. 487–491.	UK
20. Wilson, S. and Mandelbrote, B. (1978b), 'Drug rehabilitation and criminality — factors related to conviction after treatment in a therapeutic community', <i>British Journal of Criminology</i> 18, pp. 381–386.	UK
21. Ogborne, A. C. and Melotte, C. (1977), 'An evaluation of a therapeutic community for former drug users', <i>British Journal of Addiction</i> 72, pp. 75–82.	UK

Seven papers were excluded from this review for the following reasons: only during-treatment outcomes reported ( $n = 5$ ); report of secondary analyses of previously published data ( $n = 1$ ); and analysis of outcome correlates ( $n = 1$ ) (see Annex F).

The 21 included papers (Table 3.4) were based on a total of 14 unique studies (a number of papers derived from one study were accessed and included where they

reported different outcomes, e.g. Lopez-Goni et al., 2010, 2011) — for more details see Annex B. All papers reported research conducted in west European countries. At the time of writing of this report, one study using an observational design and evaluating TC treatment outcome in the Czech Republic has been concluded. As descriptive data from this research were accessed only by the review team, this study was not included in subsequent reporting on this occasion.

TABLE 3.4

**Details of observational studies included in the review**

Type of study design	Observational studies			
	Study	Study code	Substance use outcome	Criminal offences
<b>Retrospective cohort</b>	Lopez-Goni et al. (2011)	A		
	Lopez-Goni et al. (2010)	B	•	
	Fernandez-Montalvo et al. (2008)	C	•	•
	Quercioli et al. (2007)	D	•	
	Quercioli et al. (2006)	E		
	Berg et al. (2003)	F	•	
	Keen et al. (2001)	G		
	Fredersdorf (2000)	H	•	
	Wilson and Mandelbrote (1978a)	I		•
	Wilson and Mandelbrote (1978b)	J		
	Ogborne and Melotte (1977)	K	•	
<b>Retrospective sequential cohort</b>	Fernandez-Hermida et al. (2002)	L	•	•
<b>Prospective cohort</b>	Lopez-Fernandez et al. (2011)	M	•	
	Salamina et al. (2010)	N		
	Davoli et al. (2007)	O		
	Ravndal and Vaglum (1998)	P	•	
	Van de Velde et al. (1998)	Q	•	•
	Kooyman (1992)	R	•	
	Ravndal and Vaglum (1992)	S		
	Uchtenhagen and Zimmer-Höfler (1987)	T		
	Wilson and Mandelbrote (1985)	U		

All reviewed observational studies were published between 1977 and 2012. This is a relatively low number of publications compared with the multitude of observational studies conducted in the USA during the same period (De Leon, 2010). With the exception of the Italian VEdTTE (study O), none of the large-scale multicentre national drug treatment outcome studies in Europe [e.g. the United Kingdom's National Treatment Outcome Research Study (NTORS) or the follow-up to NTORS, the Drug Treatment Outcome Research Study (DTORS)] has reported data on TCs separately, and for that reason they were not considered for review here. All retrieved publications reported outcome evaluation of standard addiction TCs treatment, and none of the papers related to the modified TCs treatment outcome

for specific populations or prison-based TC treatment and outcome.

Outcomes were commonly reported in the domains of substance use, employment and social functioning, with change assessed between baseline [TC treatment entry or at the point of leaving TC treatment (completion or dropout)] and follow-up [ranging from 3 months (L) to 13 years (C)].

### Substance use

A measure of abstinence was used in four studies (H, K, R, S). These were self-reported data indicating

abstinence of 17 % at 6 months (study K), 32 % at 49 ( $\pm$  12) months (study R) and 20 % at 60 months following TC treatment (study P). Fredersdorf's assessment of abstinence (study H) was reported at about 60 %, although a time point was not easy to assign as evaluation occurred at any time between 12 and 60 months post treatment.

Where self-reported reduction in substance use was used to measure change in this outcome category (B, L, M, Q), studies consistently reported that considerable (non-statistically significant) to statistically significant reductions in drug and/or alcohol use occurred and were maintained during the follow-up periods. Studies C, D and F used a measure of relapse to drug use, with D and F reporting 23.8 % at 36 months post treatment and 41 % at 96 months, respectively. One study (E) used a validated measure of problem severity (ASI: Addiction Severity Index; McLellan et al., 1992) to track changes in substance use over 96 months post TC treatment — and detected a significant reduction in this domain over the follow-up period.

### Criminal offences

In the criminal activity outcome domain, three studies (C, I, L) used a measure of re-arrest/reconviction, consistently — studies I and L noted statistically significant reductions in re-arrest/reconviction. Study Q used changes in self-reported legal problems as the outcome measure, reporting pre- to post-treatment reductions.

### Predictors of post-treatment substance use and criminal offences

Although most studies indicated improved substance use and criminal involvement outcomes after TC treatment, not all participants were reported to benefit equally from this type of treatment. Most notably, TC treatment effect has been related to the length of stay in treatment and the completion of the planned duration of the treatment programme. Outcome difference between treatment completers and dropouts explored by Fernandez-Montalvo and colleagues (study C) noted that significantly greater treatment advantages were secured during treatment and maintained up to 13 years after TC treatment by residents who completed treatment versus dropouts. Similar superior gains with regard to substance use reduction were identified 9 to 15 months after TC treatment among TC treatment completers compared with dropouts (study B). Comparable differences were also observed in the employment outcome domain (study C).

### Employment and other outcomes

Overall, change in employment and other treatment outcome domains were less frequently addressed than substance use and criminal involvement. Alongside Fernandez-Montalvo et al. (study C), two other studies have looked at changes in the employment status of drug users undergoing TC treatment — with reports of significant improvement in that domain as measured 3–96 months after TC treatment (L) or improvement that did not reach statistical significance (A).

Five studies (F, O, P, S, U) assessed mortality among TC treatment residents between 18 months following the start of TC treatment (study O) and 10 years after TC treatment was completed (study U). Although no deaths were reported to have occurred during TC treatment, the first 30 days after TC treatment in VEdTTE saw a rate of 21.6 deaths per 1 000 person years (study O). Mortality was reported at 6.9 % at 36 months' follow-up (study F), 12.4 % at 60 months (study P) and 10 % at 10 years (study U).

## 3.3. Summary

We reviewed the international controlled (randomised and quasi-experimental) studies and European observational (prospective or retrospective cohort) studies evaluating TC treatment outcome. Across the articles included in the review, the main interest was in three measures. One measure was (a) self-reported primary drug use (which itself has been measured in various ways which captures what might be termed 'complete abstinence' and also might capture a different measure of 'reduced drug use at follow-up'); (b) criminal activity involvement measures; (c) death/survival/mortality; and (d) social integration.

Based on this review and analyses of controlled and observational studies, it can be concluded that there is some evidence for the effectiveness of TC treatment, at least in the USA, in terms of reduced substance use and criminal activity. Although death is an important and powerful measure, as the event is so rare it has not been chosen as the primary outcome in any of the (quasi-) experiments. A small number of studies also showed positive effects on employment, social functioning and general mental health. While positive treatment outcomes strongly correlate with treatment completion, TCs are overall less effective than other interventions with respect to treatment retention.

TC outcome research in Europe is limited to field effectiveness studies. Generally, these studies identify

positive treatment outcome, associated with longer retention in treatment and treatment completion, although these studies have major methodological problems.

Overall, the methodological quality of the included observational studies is unsatisfactory relating to, inter alia, small sample sizes and high attrition rates. None of the large national multicentre studies has reported TC outcomes separately, so there is a major gap in our knowledge on the effectiveness of TC treatment delivery in Europe. Owing to the nature of observational research design, changes in drug use or criminal involvement behaviours cannot be attributed to the receipt of treatment, as opposed to maturation of the studied cohorts or 'natural recovery' (Shadish et al., 2002). To some extent, these confounds could be readdressed by comparing the relative effectiveness of different programmes. For instance, assuming that individuals entering residential TC and day TC programmes are similar and subject to the same processes of maturation and natural recovery, any differences in outcome associated with residential TC or day TC might be considered a candidate treatment effect. The assumption, however, that drug users entering different programmes are similar is contradicted by the available data. Each major observational study of drug treatment has found significant differences among treatment groups on pre-treatment characteristics such as problem severity, treatment motivation, criminal history and social environment. As all these factors reliably correlate with TC treatment outcome [e.g. Fernandez-Hermida et al. (2002), Lopez-Goni et al. (2010, 2011)], comparisons of treatments have to take into account such group differences.

Few community-based TCs have been studied using rigorous evaluation designs that control for pre-treatment differences between TC-treated individuals and comparison condition groups. Since the turn of the century, only one controlled study of community TC treatment outcome has been conducted (Greenwood et al., 2001) using a quasi-experimental design that included a comparison group (of day TC clients) more or less well matched with the residential TC treatment group. The observation that community TCs have received less rigorous evaluations than prison TCs and, more notably, that have more recent or novel treatment approaches (e.g. OST, supervised injectable heroin treatment) may partly be because of general concerns about the generalisability of community-based treatment or non-medication-based treatment. The approaches more commonly subject to rigorous evaluation are provided with ongoing and/or intensive supervision and training to ensure implementation

fidelity, whereas traditional community-based TC programmes rarely, if at all, follow manuals or monitor fidelity. This would, however, be necessary to support claims that results could be generalised. Moreover, TCs often present moving targets, with services and staffing changing (see Chapter 2) along with changes in the treatment funding environment.

Although the effectiveness of community TCs is a clinical issue of utmost importance, the field is not yet mature enough in terms of the number of available controlled studies to be able to address this issue. TC studies in Europe are limited to observational studies, which provide the empirical groundwork for more advanced scientific knowledge on TC treatment (De Leon, 2010). At present, our knowledge is based on evidence of effectiveness from one US-controlled study since the turn of the century. The rest of the controlled research was conducted some 15–20 years ago on the long-term residential TC model. Thus, further research would be needed to establish the effectiveness of TC treatment. The field desperately needs a RCT with a well-defined population and a standardised treatment programme. Even one small, tightly controlled study under effectiveness conditions (routine clients, clinicians and programmes) would be a considerable step forward. Careful attention to engagement and retention of clients in treatment will be necessary to achieve a successful trial. Given the promising results of TC treatment on social reintegration and the growing interest in recovery as a treatment objective beyond stabilisation and improved health conditions, such an investment might be worthwhile under the existing financial conditions.

### 3.4. Limitations

This review is subject to several limitations. First, all selected studies have been published in peer-reviewed journals — and, while this presents some form of quality control, it may have introduced a selection bias as the likelihood of retrieving non-English-language articles might have been limited in this way. Nonetheless, published reports of TC outcome research conducted in Spain, Italy and Norway were accessed.

Second, across the studies, substance use and criminal activity involvement outcomes were commonly measured by self-report, which may not be the most accurate measurement approach, as self-reports are subject to a number of well-known biases (Morral et al., 2000). Nonetheless, there is some evidence to suggest that verbal self-report procedures in research can provide useful estimates of consumption in clinical



settings when conditions are designed to maximise the accuracy of responses (Del Boca and Darkes, 2003). Furthermore, in comparative research, biases in self-reports should affect only conclusions about outcome differences to the extent that individuals in one treatment condition are more or less biased in their reporting, i.e. biases vary by condition (known as differential reporting), which is unlikely to be the case in the included controlled studies.

Third, substantial variance from client profiles and treatment fidelity need to be acknowledged. TC programmes today address the needs of a wide range of different drug user populations, such as dually diagnosed clients and other specific client groups — and, related to that, a variety of treatment components and modifications in terms of programme length, intensity and delivery setting have been introduced. This heterogeneity has also been recognised in previous reviews (e.g. Smith et al., 2006; De Leon, 2010) and should be taken into account when reading the TC literature. Nonetheless, the TC is an internationally accepted addiction treatment method with distinctive features (Chapter 1), shared to a lesser or greater extent by all TC programmes, which allows the collective review of TC research, as well as review of the clinical experience with this treatment modality across countries and cultures (Goethals et al., 2011). Although the underlying elements may be fairly similar across TC programmes, the dose of the programme and fidelity to the TC concept may vary considerably. Very few of the reviewed studies have included a measure of TC treatment fidelity, such as SEEQ [Survey of Essential Elements Questionnaire (Melnick and De Leon, 1999)], leaving the question open as to the degree of TC programme implementation in accordance with established TC principles and essential therapeutic elements.

Treatment dropout and study attrition may further compromise the validity of the results of controlled as well as observational studies. Consequently, several studies have included only substance users who stayed in a TC for a substantial period or who completed treatment, but these findings can hardly be generalised to all persons starting TC treatment. Drop-out during the early phase of TC treatment is a well-documented phenomenon and should be taken into account when evaluating the effectiveness of TCs (Smith et al., 2006).

Smith and colleagues (2006) have suggested that large pragmatic studies, which evaluate objective outcomes that can be easily followed up for everyone randomised (e.g. based on national health registers), should be set up to minimise the number of missing data. Also, survival analyses, that is, the use of time to event outcome to

allow retention of all study recruits in the statistical analyses, should be considered, in order to answer questions about post-treatment patterns of non-drug use, sustained positive quality of life, and other changes relevant to the individual, his or her family and close networks and society at large.

### 3.5. Conclusions

The most obvious benefits of TC treatment over other interventions are lower substance use and recidivism rates in more than half of all selected studies, although the nature of the findings was not unequivocal across all controlled studies, and sample characteristics differed greatly. These positive findings have consistently been found in prison and community settings, regardless of the type of controls. In several studies modified TCs appeared to produce superior outcomes compared with standard TC treatment, illustrating the need for TC programmes to evolve and adapt to new developments and changing populations. Follow-up periods varied greatly, but outcomes were usually measured after 12–18 months. A small number of studies have assessed clients' functioning beyond this period and — although significant benefits of TC treatment have been found five years later — differential effects declined over time.

Treatment in TCs takes time, usually 6–12 months (Lees et al., 2004). This lengthy treatment period heightens the possibility that patients leave the TC prematurely. Furthermore, many drug addicts are not ready for long-term drug treatment or are not interested in this type of residential group treatment. Treatment in TCs should therefore be considered as a specific intervention, reserved for drug addicts with multiple and severe problems. Although two-thirds of all opiate addicts follow outpatient substitution treatment, a substantial number of persons may not do well in outpatient treatment because of a lack of structure and support in the community and the fact that they live in neighbourhoods in which drugs are pervasive. In addition, individuals may lack the internal control and refusal skills to resist craving and social pressure to use substances (Drake et al., 2002). For these drug users, TCs are supportive places where clients can learn the skills conducive to living a sober and rewarding life. Still, more information is needed on who benefits most from residential treatment and at what point in the recovery process.

Research is needed on whether treatment engagement can be enhanced by adding an induction programme to

the TC treatment, shortening the programme length, introducing contingency management or motivational interviewing or developing outreach strategies. Without losing the overall concept of the TC, a more flexible approach is needed to answer individual clients' needs. If treatment completion is the best predictor of positive outcomes, then TCs need to think about best practices for discharge and gradual preparation for the end of treatment, so that more residents reach the final phase of treatment and complete it.

The results of field effectiveness studies in Europe are in line with those from controlled studies, although the lack of a control condition and the generally lower methodological quality does not allow attribution of these findings to the TC treatment per se. While controlled studies usually had a follow-up period of no more than 12–18 months, field effectiveness studies have followed up TC residents for up to five years or more after treatment, showing abstinence rates between 20 % and 40 %, in particular among persons who completed the whole TC programme and who stayed in treatment for a substantial period of time.

Because of the variance in client profiles it is yet to be established who benefits from TC treatment (and at what point in the recovery process). As residential TC programmes are more expensive than outpatient

programmes, it is difficult to justify referral to residential TCs of clients who would respond to less intensive services. However, because the treatment and care of clients at the more severe end of the spectrum (e.g. dual disorder clients who are frequently homeless, incarcerated or hospitalised) is also very expensive, and because they tend to respond poorly to treatment, these clients may be good candidates for residential treatment. Moreover, a cost analysis (French et al., 1999) showed that the most effective TC residential treatments cost about the same as outpatient parallel treatment, mainly because the clients in outpatient treatment used more than twice as many hospital days and eight times as many accident and emergency visits as the clients in the residential programme.

Given the high costs of the specialised treatment used in TCs, evaluation of the cost-effectiveness of European TCs is another issue for future research. More research is needed not only on the question of whether or not TC treatment works but also on what ingredients make it work and for which drug addicts is a TC the optimal treatment modality. Finally, narrative reviews such as this provide a comprehensive overview of the available literature, but do not allow us to weigh findings from different studies or estimate effect sizes. A meta-analysis based on the selected controlled studies could provide more insight to these unanswered questions.





4

## CHAPTER 4

# Therapeutic community standards and guidelines

The development and implementation of evidence-based clinical guidelines and service standards can play an important role in quality assurance and improvement processes in TCs (EMCDDA, 2011). However, the development and implementation of standards and guidelines in TCs are subject to serious discussion (Lees, 2003). A tension can be observed between external pressures for accountability on the one hand and the concerns of the TC staff members on the other hand. The latter not only are concerned for their clinical autonomy but also express doubts about the possibility of setting standards for a complex and ever-changing therapeutic approach such as the TC. It seems that standards developed for TCs are less operational than those for medically based treatment approaches (e.g. OST) and also need to reflect the daily living and learning circumstances of residents in TCs.

In this chapter, available guidelines and standards for TC treatment will be presented, based on the results of a literature search and information sourced from the following international TC bodies: the Community of Communities (CofC), the Association of Therapeutic Communities, the EFTC and the WFTC.

Three sets of non-country-specific standards and guidelines were identified: Survey of Essential Elements

Questionnaire (SEEQ; Melnick and De Leon, 1999); Service Standards for European TCs for Addiction (CofC <sup>(3)</sup>) and Standards and Goals (WFTC).

### 4.1. Survey of Essential Elements Questionnaire

The SEEQ is an instrument developed in 1999 by Melnick and De Leon and is based on the theoretical framework of the TC model as described by De Leon (1995). The SEEQ was developed as a response to increasing concerns about the quality and effectiveness of the TC approach (Melnick and De Leon, 1999). It is a self-administered instrument consisting of 139 Likert scale items with a range from 0 (objectionable) and 1 (very little importance) to 5 (extremely important) (Melnick and De Leon, 1999, p. 309). The instrument has six broad dimensions, each of which is divided into a number of domains. The dimensions cover the various components of TC treatment, whereas the domains cover the philosophy and core treatment elements of drug-free, hierarchical, concept-based TCs. An overview of all dimensions and domains is listed in Table 4.1.

<sup>(3)</sup> <http://www.druglibrary.stir.ac.uk/documents/tc.servicestandards.ed1.pdf>

TABLE 4.1

**Dimensions and domains of the SEEQ (\*)**

Dimension	Domains
TC perspective	View of the addictive disorder View of the addict View of recovery View of right living
Treatment approach and structure: <i>'provides the framework of the therapeutic process. Ideally, the structure augments the therapeutic aims and is comprised of the managerial procedures consisting of the lines of authority along with the agency's policies, rules and regulations'</i>	Programme organisation Treatment approach Staff roles and functions Clients' role and functions Healthcare
Community as therapeutic agent: <i>'use of the community as therapeutic agent and the strengthening of therapeutic bonds'</i>	Peers as gatekeepers Mutual help Community belonging Contact with the outside community Positive and negative behavioural reinforcement tools (privileges and sanctions)
Educational and work activities: <i>'the extent to which both informal and formal education and training are included as integral components of the overall program and used to support the therapeutic aims'</i>	Formal educational elements Therapeutic educational elements Work as therapy
Formal therapeutic elements: <i>'these include behavior modifications, group meetings, counseling techniques, family in therapy'</i>	General therapeutic techniques Groups as therapeutic agents Counselling techniques Role of the family
Process: <i>'rehabilitation in the TC unfolds as a developmental process which may be understood as a passage through several stages of incremental learning'</i>	Stages of treatment Introductory period Primary treatment stage Community re-entry period
<p>A recent comparative study (Goethals et al., 2011) that made use of the SEEQ revealed several similarities between European TCs as and their American predecessors and revealed that there is — indeed — scientific evidence for the hypothesis that there is an underlying 'generic' model for TCs for addictions. Goethals et al. (2011, p. 1028) conclude the following:</p> <p><i>All TCs subscribe to the same perspective on recovery and right living and strongly adhere to the treatment approach and structure, except for educational classes that focus on health issues. They also view peers as gatekeepers that protect community values, manage daily activities to endorse community participation, gradually involve the outside community, and use sanctions for norms violations. In addition, all TC programs obtain clients' social and psychological development through the use of behavior modification techniques, educational classes, and work. And, finally, they all share a similar perspective on the TC process that clients gradually move through three different stages each with their own specific goals and expectations.</i></p>	

(\*) Based on an integration of Melnick and De Leon (1999) and Goethals et al. (2011). Text in italics is quoted from Goethals et al. (2011), p. 1030.

## 4.2. Service standards for European therapeutic communities for addiction

The service standards for addiction TCs in Europe were conceived and developed as a collaborative project led by the Royal College of Psychiatrists, London, UK, with the participation and involvement of a diverse group of stakeholders from across Europe and beyond (Shah and Paget, 2006).

The standards are organised in six sections: core standards; physical environment; staff joining and leaving; therapeutic environment; treatment programme;

and external relations. The core standards address vital features that all TC programmes should strive to satisfy (Table 4.2). The remaining sections address specific areas as listed above. The standards represent an ideal practice and are to be seen as guiding principles, in that not every TC is expected to meet every standard.

The Community of Communities (CofC) network brings together TCs from Europe and beyond, engaging them in service evaluation and service provision quality improvement. At present, the service standards are being implemented in the United Kingdom and they have the potential to be used on a Europe-wide scale.

TABLE 4.2

**Core service standards**

Number	Core standard
CS1	The whole community meets regularly
CS2	All community members work alongside each other on day-to-day tasks
CS3	All community members share social time together
CS4	Members of the community share meals together
CS5	Community members take a variety of roles and levels of responsibility
CS6	Informal aspects of everyday living are integral to the work of the community
CS7	All community members can discuss any aspects of life within the community
CS8	All community members regularly examine their attitudes and feelings towards each other
CS9	All community members share responsibility for each other
CS10	All community members create an emotionally safe environment for the work of the community
CS11	Community members are involved in the selection of new staff members
CS12	All community members participate in the process of a new client member joining the community
CS13	Community members are involved in making plans with a client member for when he or she completes the programme
CS14	There is an understanding and tolerance of disturbed behaviour and emotional expression
CS15	Positive risk taking is seen as an essential part of the process of change
CS16	The therapeutic community has a clear set of boundaries, limits or rules which are understood by all members

Source: Shah and Paget (2006).

### 4.3. Standards and goals of the World Federation of Therapeutic Communities

All TCs that apply for membership of the WFTC are required to subscribe and adhere to the WFTC's standards and goals for TCs. By doing so, TCs endorse that 'therapeutic communities represent a design of

treatment which is directed primarily towards recovery from substance abuse through personal growth and which requires abstinence from mood-altering substances, including prescription drugs used illegally' (WFTC, 2012). Next, the members are required to subscribe to a number of standards and goals, as described in Table 4.3. These same standards and goals were adopted by the EFTC.

TABLE 4.3

Extract from the Standards and Goals for Therapeutic Communities of the WFTC (2012)	
The members of the World Federation of Therapeutic Communities are required to:	
(a)	Recognise the human and civil rights of all persons associated with their therapeutic community and clearly state the rights, privileges and responsibilities of clients and staff.
(b)	Vest in each individual within the therapeutic community the right to be free from the threat of the negative use of power by any individual or group.
(c)	Develop a statement on the philosophy and goals of the programme.
(d)	Adopt regulations for their therapeutic community which afford protection from apparent or actual abrogation of local and national laws.
(e)	Function within environments which provide maximum opportunity for physical, spiritual, emotional and aesthetic development and which will ensure the safety of everyone.
(f)	Facilitate the structure of a society/community-based on the optimal use of the integrity, good will and humanity of all its members in which the dignity of persons is a priority value.
(g)	Train and provide adequate supervision for staff.
(h)	Be accountable to an external Executive or Community Board with meetings predetermined and at regular intervals during the year for the purpose of maintaining supervision and responsibility for the activities of the programme and each facility.
(i)	Produce an annual audited financial report, authorised by the member's Executive or Community Board.

#### 4.4. Standards and guidelines in the selected countries

In addition to the general guidelines and standards, a number of guidelines and standards are being developed and implemented by individual countries.

In Spain, Proyecto Hombre, one of the largest drug treatment networks in the country, has developed manuals and guidelines in order to support evidence-based treatment in TCs and other treatment modalities. The 'Manual de adicciones para psicólogos especialistas en psicología clínica en formación', coordinated by Elisardo Becoña and Maite Cortés (2011), is one such example.

In Poland, quality standards were developed by the National Bureau for Prevention of Drug Abuse for all non-governmental organisations working in the field of substance abuse prevention and treatment. The TCs that receive funding from this national bureau are obliged to comply with these standards (Moskalewicz, 2009). In order to be reimbursed by the National Health Insurance Fund, residential treatment centres must also comply with certain conditions, as included in the law on public health institutions and the law on drug prevention. The legally defined criteria concern personnel employed, professional and ethical standards, types of services and some other criteria (Koczurowska, 2006).

In the Czech Republic, the Government Council for Drug Policy Coordination (GCDPC) has developed and implemented certification standards for a wide range of medical, social and medical–social services that are active in the field of drug treatment. The standards consist of a general and a specific part. The general part provides a number of general quality standards, whereas the specific part consists of specific standards for each type of treatment, e.g. residential care in TCs. In order to be certified as a TC, services have to meet a certain percentage of all criteria with specific targets related to the so-called 'required' criteria. Furthermore, the leaders of 12 TCs also signed the ethical code of the TC Department of the Association of Non-Profit Organization (ANO), including an ethical code for the staff, a list of clients' rights and aims and standards of TCs. Currently, the implementation process of the standards is somewhat disrupted as a result of difficulties related to policy coordination between ministries and departments, as each department or ministry (e.g. health or labour) prefers to apply its own criteria and procedures for evaluating quality.

A number of observations and comments are noted below on the available TC standards. To date, there is no consensus on the definitions or distinctions between standards, practices and service goals for TCs. For example, WFTC standards and goals emphasise clients' rights, safety and optimal environments which promote growth and development and programme accountability. These generic requirements do not illuminate the standards that relate to the unique clinical and social learning features of the TC approach, specifically community as method, although the service standards for addiction TCs of the CofC (Shah and Paget, 2006; CofC, 2012 a,b) and the Czech efforts are promising.

The core standards listed in Table 4.2 do capture elements of TCs; if these elements are absent, the programme is less likely to be a TC. However, they reflect a mixture of structural elements, various practices, beliefs, principles, and so on. Definitions and distinctions are needed among these terms, as well as the rationale (theoretical basis) for each standard.

The topic of standards requires at least a brief discussion of TC fidelity, that is, how closely TC programmes adhere to the theory, model and method of the TC. Standards can be defined as minimum criteria for assuring appropriate implementation of TC programmes. The core elements (i.e. standards) may be present in a programme, but how well they are implemented and/or practised further illustrates the issue of TC fidelity. For example, a core TC element, the morning meeting, is a community activity that meets the minimal criterion definition of a TC standard. However, guidelines are needed to assure optimal functioning of the morning meeting — that is, how and why the morning meeting is implemented and whether this activity achieves its objective.

This discussion is critical, as the variability in outcomes across programmes and cultures may reflect issues around how well the TC approach is implemented. Indeed, a major limitation in all of the outcome literature reviews, including the meta-analytical evaluations, is the absence of fidelity assessments. There are models for assessing fidelity in terms of both whether or not standards are present (such as the CofC) and how well standards are implemented/practised. An example of the latter may be evaluating whether staff and residents understand the reason or rationale for the standard.

A fuller set of national standards and guidelines with relevance to TCs is provided in another EMCDDA publication (EMCDDA paper on residential treatment for drug users in Europe, in press).

## 4.5. Conclusion

It is crucial that uniformity is achieved in TC standards as well as in the models of TC fidelity assessments. This infers consensus on the core elements of the programme model, the method and theory (the clinical or management rationale) underlying the core elements and, although not discussed in this publication, the critical implications for uniform training models.

5



## CHAPTER 5

# Therapeutic communities in Europe: recent developments and future challenges

### 5.1. Good times, bad times and new developments

Therapeutic communities (TCs) as defined in this report — drug-free, hierarchical, concept-based — are among the longest standing treatment modalities for drug addicts in Europe. In most European countries, TCs were the first treatment solution in response to the emerging drug problems in the 1960s and 1970s. Sourced from the traditions of democratic TCs and planned environment therapy for so-called ‘maladjusted children’ (the United Kingdom), psychoanalysis (France) and TC treatment for alcohol dependence (the Czech Republic), this originally US model has been adapted to the European context, adopting its own European TC identity (Broekaert, 2006a). TCs promote changes towards a drug-free lifestyle through living together in a structured way for a substantial period of time. This approach was in line with the early drug policies in most European countries that focused on total abstinence and rehabilitation of drug addicts. Existing institutions were not willing or able to treat this new group of persons, alternative treatments were not available and a considerable number of volunteers involved in TCs helped to intervene at limited public cost.

The advent of the HIV/AIDS epidemic in the mid-1980s, however, posed new challenges for national drug treatment systems. The ever-growing population of drug users exhibiting complex clinical profiles and treatment needs has prompted the development and growth of OST and harm reduction measures to contain the spread of drug use-related infectious diseases in Europe. With an emphasis on abstinence and a high threshold for treatment entry, TCs were driven out into the periphery of drug treatment systems.

While the clinical effectiveness and cost-effectiveness of OST as a treatment option has been repeatedly confirmed using rigorous research designs, the evidence

base behind TCs is yet to be strengthened. Mature methodologies are yet to be applied to the study of TCs in Europe and, to date, the lack of randomised controlled studies has prevented TCs from establishing themselves as a prominent model of treatment and care, with the exception of a few countries in the south and east of Europe (e.g. Spain, Italy and Poland) where TC bed space is relatively high.

Over recent decades, other (residential) treatment modalities have adopted typical TC tools, such as the structuring of daily life or the confrontation of one’s behaviour during group therapy sessions. TCs have also moved into specific niches such as treatment of drug users with dual diagnoses, mothers with children, and prison inmates.

### 5.2. Therapeutic communities in the future

The future of TCs will depend on how well these programmes continue to target areas where they can make the most impact and achieve the most good at adequate cost. This means continuing the implementation of modified TC programmes for particularly vulnerable populations, such as the homeless and those with co-existing disorders, as well as establishing programmes in a range of settings, including prison. A few European countries (Spain, Romania, the United Kingdom) have introduced TCs to the prison setting. While positive outcomes from prison-based TCs have been reported in the literature from the USA, these findings may not be directly translated into the European context — randomised controlled studies of European TCs need to be carried out to investigate the clinical efficacy and economic value of these programmes.

While there was a strained relation between abstinence-oriented and harm reduction programmes during the 1990s, today TC treatment, OST and harm reduction initiatives are increasingly becoming better attuned to each other. In fact, they serve the same clients and persons in OST today can simultaneously access residential TC treatment. If more European facilities providing TC interventions are to treat OST clients, it will be vital to document treatment outcome as well as encouraging collaboration between these services and regular screening and monitoring of drug users' needs. While OST has proven its effectiveness with respect to health conditions and use of illicit drugs, TCs can look to the long-term perspectives of reintegration, social inclusion or drug abstinence.

The TC movement has become reconciled to approaches that advocate the introduction of shorter programmes and outreach and community-based interventions. For example, the length of the residential treatment phase has been reduced in most countries to around 12 months or less. A growing emphasis on expenditure containment is likely to contribute to further reductions in the planned duration of TC treatment episodes, as well as a number of other possible changes to the TC model and the way it is practised. This includes an emphasis on the role of informal volunteers and self-help elements at the expense of 'professional' staff members, akin to North American TC programmes. The ways in which the quantity and, more importantly, the quality of the TC intervention are negotiated will determine its future role in addiction treatment.

Throughout the history of addiction TCs in Europe, a number of programmes have been referred to as a sect

(Broekaert et al., 2006), steered by charismatic leadership and not subject to external controls. Today, governmental control and adherence to standards such as the standards and ethics code formulated by the WFTC provide a general framework for TC professionals. For accreditation purposes and continued quality control, however, more detailed standards are necessary and the set of 'Service Standards for Addiction Therapeutic Communities' developed by the Community of Communities (CofC, 2012a, b) is an encouraging example. Although quality control in TCs in most countries is limited to staffing issues, TCs themselves appear to be open to more in-depth and comprehensive assessment and accreditation of their services. The Survey of Essential Elements Questionnaire' (De Leon and Melnick, 1993; Melnick and De Leon, 1999) is potentially a candidate instrument with uses in the assessment of TC essential treatment elements, and therefore as an indicator of treatment fidelity. This may also help to reduce the heterogeneity of the concepts provided in Europe under the name of 'TC'.

In conclusion, TC programmes for the rehabilitation of drug users are established in many European countries and play a role as part of the national addiction treatment systems. There is some evidence for the effectiveness of TCs in terms of reduced substance use and criminal activity, at least in the USA and a culture of TC research is being developed in Europe. This review has documented the available evidence and current TC practices in the Member States, with a focus on improving knowledge and, ultimately, the quality of care and service provision in TC programmes in Europe.

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# Annexes

## Abbreviations used in the annexes

<b>ASI</b>	Addiction Severity Index
<b>BDI</b>	Beck Depression Inventory
<b>CI</b>	confidence interval
<b>HIV</b>	human immunodeficiency virus
<b>HR</b>	hazard ratio
<b>MMT</b>	methadone maintenance treatment
<b>MTC</b>	modified therapeutic community
<b>OR</b>	odds ratio
<b>Other</b>	other therapeutic community modality
<b>PY</b>	person years
<b>QES</b>	quasi-experimental study
<b>RCI</b>	Reliable Change Index
<b>RCT</b>	randomised controlled trial
<b>SCL-90-R</b>	Symptom Checklist-90-Revised
<b>TAU</b>	treatment as usual
<b>TC</b>	therapeutic community
<b>TTC</b>	traditional therapeutic community

## Annex A

### International therapeutic communities controlled studies: features and outcomes

Reference and country	Type of study design	Time to follow-up	Study population	Groups studied <sup>(1)</sup>	Follow-up rate <sup>(2)</sup>	Outcomes			
						Retention <sup>(3)</sup>	Substance use <sup>(4)</sup>	Crime <sup>(5)</sup>	Employment <sup>(6)</sup> Other <sup>(7)</sup>
1. Sacks et al., 2012 (USA, Colorado)	QES	12 months following TC entry	127 male offenders with substance use and mental health disorders in receipt of prison treatment	MTC (n = 71) 6-month programme Comparison condition: parole supervision case management (n = 56)	86.6 %			Self-reported drug offences: MTC 37.0 % vs. parole supervision 58.0 % (*) Reincarceration: MTC 19.0 % vs. parole supervision 38.0 % (*) Self-reported criminal activity: MTC 39.0 % vs. parole supervision 62.0 % (*) Days to reincarceration: MTC 161 vs. parole supervision 168 (*)	
2. Zhang et al., 2011 (USA, California)	QES	12 months following TC prison release  60 months after prison release	798 male offenders with documented history of substance use	Prison-based TC (n = 395) 18-month programme Comparison condition: matched group of untreated prison inmates (n = 403)	100 % (official records data)			Re-arrest: prison TC 54.0 % vs. no treatment 47.6 % (ns) Reincarceration: prison TC 54.7 % vs. no treatment 51.9 % (ns)  Re-arrest: prison TC 80.4 % vs. no treatment 78.2% (ns) Reincarceration: prison TC 72.4 % vs. no treatment 72.5 % (ns) Days in prison: prison TC 450.4 vs. no treatment 412.7 (ns)	
3. Messina et al., 2010 (USA, California)	RCT	6 and 12 months post release	115 female offenders with documented history of substance use	Gender-responsive MTC in prison (n = 60) 6-month programme Control group: standard prison TC (n = 55) 6-month programme	83.0 % at 6 months  76.0 % at 12 months	Months in aftercare: MTC 2.6 vs. standard prison TC 1.8 (*)	ASI alcohol and drug composite scores (ns)	Return to custody: prison MTC 31.0 % vs. standard prison TC 45.0 % (ns)	ASI family and psychological composite scores (ns)
4. Welsh, 2007 (USA, Pennsylvania)	QES	24 months post prison release	708 male inmates in prison drug treatment	Prison TC (n = 217) Length of planned treatment programme varied from 9 (n = 1) to 12 (n = 3) and 16 months (n = 1) Comparison conditions: other drug treatment (drug education, self-help groups) (n = 491)	100 %		Reduction in drug use measured by urine drug screen: prison TC 35.0 vs. other drug treatment in prison 38.0 % (ns)	Reduction in reincarceration: prison TC 30.0 vs. other drug treatment in prison 24.0 % (*); Reduction in re-arrest: prison TC 41.0 % vs. other drug treatment in prison 34.0 % (*)	Prison TC 39.2 % vs. other drug treatment in prison 25.9 % (***)

(1) Type of TC or type of control condition. Planned duration of the treatment programme is noted if specified in the original source.

(2) Proportion of original sample successfully followed up.

(3) Rate of retention in treatment for the planned treatment duration; time spent in treatment; treatment completion rate.

(4) Abstinence or relapse rates; time to first use following treatment.

(5) Recidivism or re-arrest rates; reincarceration; ASI score.

(6) Proportion employed.

(7) Homelessness; psychiatric disorders; quality of life.

	Reference and country	Type of study design	Time to follow-up	Study population	Groups studied (1)	Follow-up rate (2)	Outcomes					
							Retention (3)	Substance use (4)	Crime (5)	Employment (6)	Other (7)	
5.	Sullivan et al., 2007 (USA, Colorado)	RCT	12 months post release	139 male inmates with substance use and other psychiatric disorders	Prison MTC (n = 75) 12-month programme Control group: standard mental health treatment in prison (n = 64)	75.0 %		Self-reported use of any substance: prison MTC 31.0 % vs. standard treatment in prison 56.0 % (**) Self-reported use of any illicit drug: prison MTC 25.0 % vs. standard treatment in prison 44.0 % (*) Self-reported alcohol intoxication: prison MTC 21.0 % vs. standard treatment in prison 39.0 % (*) Time to relapse: prison MTC 3.7 vs. standard treatment in prison 2.6 months (*)				
6.	Sacks et al., 2004 (USA, Colorado)	QES	12 months post prison release	185 male inmates with substance use and other psychiatric disorders	Prison MTC (n = 92) 12-month programme Comparison condition: standard mental health treatment (n = 93)	75.0 %			Reincarceration: prison MTC 9.0 % vs. standard treatment in prison 33.0 % (**)			
7.	Morral et al., 2004 (USA, California)	QES	12 months after start of TC programme	449 adolescent probationers with substance use problems	MTC in prison (n = 175) 9-month programme Comparison condition: alternative probation (n = 274)	90.8 % at 3 months	ns	Reduction in substance use on three measures: substance problem index; substance use density index; and substance involvement scale (past 90 days): TC vs. alternative probation (effect size on all three measures of around -0.25) (*)	Reduction in criminal involvement scales: TC vs. alternative probation (ns)		Reduction in somatic and anxiety symptoms as measured by the somatic symptoms index and the ASI (effect sizes of around -0.29) (*)	
8.	Inciardi et al., 2004 (USA, Delaware)	QES (group assignment by correctional staff)	42 and 60 months post release	690 male inmates with substance use problems	Prison TC Comparison condition: no treatment	69.8 % at 42 months; 63.8 % at 60 months		Self-reported abstinence: prison TC group four times more likely than no-treatment group to be drug-free at 42 months, OR = 4.49 (***) and 60 months, OR = 3.54 (***)	Self-reported abstinence and re-arrest: prison TC group two times more likely than no-treatment group to be drug and crime problem free at 42 months, OR = 1.71 (**) and at 60 months, OR = 1.61 (*)			

	Reference and country	Type of study design	Time to follow-up	Study population	Groups studied (1)	Follow-up rate (2)	Outcomes				
							Retention (3)	Substance use (4)	Crime (5)	Employment (6)	Other (7)
9.	Martin et al., 1999 (USA, Delaware)	QES	18 months post release	428 inmates with drug use problems	Prison TC (KEY) + transitional TC (CREST) (n = 68) Comparison conditions: prison TC (KEY) (n = 38) 12-month programme Transitional TC (CREST) (n = 157) 6-month programme Regular work release (n = 165)	80.0 %		Self-reported abstinence: KEY + CREST 47.0 % vs. CREST 31.0 % vs. regular work release 16.0 % (*)	No re-arrest: KEY + CREST 77.0 % vs. CREST 57.0 % vs. regular work release 46.0 % (*)		
10.	Lockwood et al., 1997 (USA, Delaware)	QES	6 months post release	483 inmates with history of substance use	Prison TC (KEY) + transitional TC (CREST) (n = 90) Comparison conditions: prison TC (KEY) (n = 58) 12-month programme Transitional TC (CREST) (n = 157) 6-month programme Standard work release (n = 165)	80.0 %		Self-reported abstinence: KEY + CREST 93.3 % vs. KEY 87.0 % vs. CREST 71.0 % vs. standard work release 73.7 % (*)	No arrest: KEY + CREST 97.1 % vs. KEY 86.5 % vs. CREST 75.0 % vs. standard work release 59.9 % (**)		
11.	Nielsen et al., 1996 (USA, Delaware)	QES	6 and 18 months post release	689 inmates with history of substance use	Transitional TC (CREST) (n = 248) 6-month programme Comparison condition: standard work release (n = 441)	Transitional TC 77.0 and standard work release 72.6 % at 6 months Transitional TC 58.5 % and standard work release 6.7 % at 18 months		Self-reported relapse: transitional TC 16.2 % vs. standard work release 62.2 % (***) at 6 months Self-reported relapse: transitional TC 51.7 % vs. standard work release 79.0 % (***) at 18 months	Self-reported recidivism: transitional TC 14.7 % vs. standard work release 35.4 % (***) Self-reported recidivism: transitional TC 38.2 % vs. standard work release 63.0 % (***)		
12.	Prendergast et al., 2004 (USA, California)	RCT	60 months post release	715 male inmates with substance abuse problems	Prison TC (n = 425) 9- to 12-month programme Control group: no treatment (waiting list) (n = 290)	81.2 %	Months in aftercare: prison TC 4.6 vs. no treatment 1.7	Self-reported 'heavy drug use' during past year: prison TC 24.9 % vs. no treatment 22.6 %	Reincarceration: prison TC 75.7 % vs. no treatment 83.4 % (*) Days to reincarceration: prison TC 634 vs. no treatment 809 days (***)	Stable job in past year: prison TC 54.8 % vs. no treatment 52.3 % (ns)	Psychological distress: prison TC 31.8 % vs. no treatment 44.6 % (*)
13.	Prendergast et al., 2003 (USA, California)	RCT	12 months post release	715 male inmates with substance use problems	Prison TC (n = 425) 9- to 12-month programme Control group: no treatment (waiting list) (n = 290)	74.0 %		Time to first drug use: prison TC 77.0 vs. no treatment 31 days (***)	Reincarceration: prison TC 33.9 % vs. no treatment 49.7 % (*) Days to first illegal activity: prison TC 138 vs. no treatment 71 days (***)		
14.	Wexler et al., 1999 (USA, California)	RCT	12 and 24 months post release	715 male inmates who volunteered for TC treatment in prison	Prison TC (n = 425) 9- to 12-month programme Control group: no treatment (waiting list) (n = 290)	100 % at 12 months 36.8 % at 24 months			Reincarceration: prison TC 33.9 % vs. no treatment 49.7 % (***) at 12 months Reincarceration: prison TC 43.3 % vs. no treatment 67.1 % (***) at 24 months		



	Reference and country	Type of study design	Time to follow-up	Study population	Groups studied (1)	Follow-up rate (2)	Outcomes			
							Retention (3)	Substance use (4)	Crime (5)	Employment (6)
15.	Greenwood et al. 2001 (USA, California)	QES	6, 12 and 18 months post treatment admission	261 substance users seeking TC treatment	Residential TC (n = 147) 12-month programme Comparison condition: day TC programme (n = 114)	82.4 % at 6 months; 82.7 % at 12 months; 82.7 % at 18 months	Residential TC 109.8 vs. day TC 102.7 days	Self-reported abstinence: residential TC 62.6 % vs. day TC 47.0 % at 6 months (*) Self-reported abstinence: residential TC 49.0 % vs. day TC 47.9 % at 12 months (ns) Self-reported abstinence: residential TC 55.2 % vs. day TC 50.4 % at 18 months (ns)		
16.	Guydish et al. 1999 (USA, California)	RCT	12 and 18 months	188 substance users retained in TC treatment for 2 weeks or more	Residential TC (n = 99) Planned treatment programme duration between 6 and 12 months Control group: day TC (n = 89) Planned length of stay between 6 and approximately 12 months		12-month retention: residential TC 9.0 % vs. day TC 17.0 %			12-month problem severity as measured by SCL-90-R: residential TC 0.56 vs. day TC 0.71 (*); 18-month problem severity as measured by SCL-90-R: residential TC 0.51 vs. day TC 0.71 (*); 12-month depression as measured by BDI: residential TC 8.6 vs day TC 11.4 (*)
17.	Guydish et al. 1998 (USA, California)	RCT	6 months	261 substance users retained in TC treatment for 2 weeks or more	Residential TC (n = 147) Planned treatment programme duration between 6 and 12 months Control group: day TC (n = 114) Planned length of stay between 6 and approximately 12 months	Residential TC: 98.0 % Day TC: 78.0 %	Retention in treatment at 6 months: residential TC 29.0 % vs. day TC 34.0 % Days in treatment: residential TC: 109.8 vs. day TC 102.7			Social functioning: residential TC 0.18 vs. day TC 0.16 (*) as measured by ASI; global problem severity: residential TC 0.75 vs. day TC 0.70 (**) as measured by SCL-90-R

	Reference and country	Type of study design	Time to follow-up	Study population	Groups studied <sup>(1)</sup>	Follow-up rate <sup>(2)</sup>	Outcomes			Employment <sup>(9)</sup>	Other <sup>(7)</sup>
							Retention <sup>(3)</sup>	Substance use <sup>(4)</sup>	Crime <sup>(5)</sup>		
18.	Nemes et al. 1999 (USA, Washington)	RCT	18 months post treatment admission	412 substance users seeking TC treatment	Standard TC (n = 194) 12-month programme (10 months inpatient, 2 months outpatient) Control groups: abbreviated TC (n = 218); 12-month programme (6 months inpatient, 6 months outpatient)	93.0 %	Treatment completion: standard TC: 33.0 % vs. abbreviated TC 38.0 % (ns)	Self-reported heroin use: standard TC 9.0 % vs. abbreviated TC 15.0 % (*)	Self-reported re-arrest: standard TC 17.0 % vs. abbreviated TC 26.0 % (**) Time to re-arrest: standard TC 9.4 months vs. abbreviated TC 6.9 months (*)	Standard TC 72.0 % vs. abbreviated TC 56.0 % (**)	
19.	De Leon et al., 2000 (USA, New York)	QES (sequential group assignment)	12 months post treatment admission	342 homeless mentally ill substance users	Low-demand TC (MTC1) (n = 183) 12-month programme vs. high-demand TC (MTC2) (n = 93) 12-month programme Comparison condition: TAU (n = 66)	MTC1: 56.0 % at 12 months MTC2: 34.0 % at 12 months		Self-reported drug use and alcohol intoxication: MTC2 less drug use and alcohol intoxication than TAU (*)	Self-reported criminal activity: MTC1 /MTC2 vs. TAU (ns)	MTC1 more likely to be employed than TAU (***) MTC2 more likely to be employed than TAU (***)	HIV risk behaviour: MTC1 and MTC2 vs. TAU (ns)
			24 months post-treatment admission					MTC2 less self-reported alcohol intoxication (*) Less self-reported substance use than TAU (*)	Self-reported criminal activity: MTC1 fewer crimes than TAU (*) MTC2 fewer crimes than TAU (***)	MTC1 more likely to be employed than TAU (***) MTC2 more likely to be employed than TAU (***)	Symptoms of depression and anxiety: MTC2 vs. TAU (*)
20.	French et al., 1999 (USA, New York)	QES (sequential group assignment)	24 months following MTC treatment entry	342 homeless mentally ill substance users	Low-demand TC (MTC1) (n = 183) 12-month programme vs. high-demand TC (MTC2) (n = 93) 12-month programme Comparison condition: TAU (n = 66)	82.0 %		Self-reported substance use: MTC vs. TAU (ns)	Self-reported criminal activity: MTC fewer crimes than TAU (*)	MTC vs TAU (ns)	Depression: MTC lower BDI score than TAU (*) Other psychological symptoms (ns)
21.	Nuttbrock et al., 1998 (USA, New York)	QES (allocation based on availability of treatment placement and client preferences)	12 months post treatment admission	290 homeless men with major mental disorder and history of substance use	MTC (n = 169) 18-month programme Comparison condition: homeless community residency (n = 121) 18-month programme		Treatment retention: MTC 43.0 % vs. homeless community residence 55.0 % at 6 months; MTC 25.0 % vs. homeless community residence 37.0 % at 12 months	Drug use detected with urine drug screen: MTC 4.1 % vs. homeless community residence 30.1 % (*) Self-reported alcohol use: MTC 0 % vs. homeless community residence 14.3 % (*) Self-reported marijuana use: MTC 2.6 % vs. homeless community residence 2.9 % (ns) Self-reported crack use: MTC 7.7 % vs. homeless community residence 14.2 % (*)			Depression, anxiety, psychiatric distress: MTC vs. homeless community residences (ns)

	Reference and country	Type of study design	Time to follow-up	Study population	Groups studied (1)	Follow-up rate (2)	Outcomes				
							Retention (3)	Substance use (4)	Crime (5)	Employment (6)	Other (7)
22.	McCusker et al., 1997 (USA, New England)	QES	3 months post treatment discharge	539 drug users entering residential TC treatment	Traditional TC programmes: 6-month (n = 86) and 12-month (n = 75) Comparison conditions: MTC programme (relapse prevention) 3-month (n = 192) and 6-month (n = 186) alternatives	86.0 % at 18 months	Treatment completion: 23.0 % in traditional 12-month TC, 34.0 % in 6-month TC, 31.0 % in long 6-month MTC and 56.0 % in 3-month MTC	Time to drug use: 6-month TC vs. 12-month TC (ns); TCs vs. MTCs (ns)	Self-reported reduction in legal problems: 6-month TC vs. 12-month TC (ns)	Higher in TC than in MTC (*)	
23.	McCusker et al., 1995 (USA, New England)	QES	3–6 months post treatment discharge	628 drug users entering residential TC and MTC treatment	Traditional TC programme [6-month (n = 97) and 12-month (n = 87) alternatives] Comparison conditions: MTC 3-month (n = 223) and 6-month alternative (n = 221)	84.0 % in TC and 74.0 % in MTC	40-day retention: 6-month TC 70.0 %; 12-month TC 85.0 %; 3-month MTC 73.0 %; 6-month MTC 72.0 % Treatment completion: 6-month TC 33.0 %; 12-month TC 21.0 %; 3-month MTC 56.0 %; 6-month MTC 30.0 % (all ns)	Self-reported relapse at 6 months: TC 50.0 % vs. MTC 44.0 % (ns)			
24.	McCusker et al., 1996 (USA, Massachusetts)	RCT	6 months post treatment discharge	444 drug users	Long MTC (n = 221) 6-month programme Control group: short MTC (n = 223) 3-month programme	74.0 %	Treatment programme completion: TC 30.0 % vs. MTC 56.0 %	Self-reported relapse to drug use in first week after leaving treatment: MTC 33.0 % vs. short MTC 70.0 % (*)			
25.	Hartmann et al., 1997 (USA, Missouri)	QES (self-selection for treatment intervention)	5 months post prison release	286 male offenders with a history of substance use	Prison TC (n = 161) treatment programme length not reported Comparison condition: eligible inmates who did not attend prison TC (n = 125)	Not reported		Self-reported abstinence: prison TC 85.4 % vs. no prison treatment 72.0 % (ns)	Reincarceration: prison TC 16.4 % vs. no prison treatment 27.6 % (*)		

	Reference and country	Type of study design	Time to follow-up	Study population	Groups studied (1)	Follow-up rate (2)	Outcomes				
							Retention (3)	Substance use (4)	Crime (5)	Employment (6)	Other (7)
26.	Bale et al., 1984 (USA, California)	QES	24 months	363 male heroin-dependent veterans	Standard TC (n = 25), MTC (n = 156) 6-month programme Comparison condition: 5-day withdrawal treatment (n = 166)	95.6 %		Self-reported abstinence from heroin: TC 40.0 % vs. MTC 48.1 % vs. withdrawal treatment 33.3 % (*) Self-reported abstinence from other illegal drug use: TC 40.0 %, MTC 41.6 % and 53.3 % vs. withdrawal treatment 39.3 % (*) Alcohol problems: TC 40.0 % and MTC 47.3 % (**) vs. withdrawal treatment 22.4 %	No conviction: TC 44.0 % vs. MTC 32.5 % vs. withdrawal treatment 31.3 % (**)	Employment or school attendance: TC 48.0 % vs. MTC 46.8 % vs. withdrawal treatment 34.0 % (**)	Mortality: TC (and MTC) 1.7 % vs. withdrawal treatment 6.6 % (*)
27.	Bale et al., 1980 (USA, California)	QES	12 months	585 male heroin-dependent veterans	TC residents retained in treatment ≥ 50 days (n = 75) or < 50 days (n = 75) Comparison conditions: MMT (n = 59); detoxification only (n = 224); detoxification followed by other addiction treatment (n = 112)	93.2 %		Self-reported heroin use: TC 37.3 % vs. other treatment 65.5 % (**)	Arrest: TC 37.3 % vs. other treatment 54.5 % (**) except MMT Reconviction: TC 21.3 % vs. other treatment 38.0 % (**) except MMT Reincarceration: TC 4.0 % vs. other treatment 21.1 % (**) except MMT	Employment/ school attendance: TC 65.3 % vs. MMT 50.9 % (***)	
28.	Coombs, 1981 (USA, California)	QES (self-selection for treatment intervention)	12 months post leaving TC treatment	207 heroin users in TC treatment	Long-term TC (n = 77) 12-month programme Comparison condition: short-term TC (n = 130) 3-month programme	78.5 %	Programme completion: 12-month programme 63.6 % vs. 3-month programme 74.6 %	Self-reported abstinence: 12-month programme 4.3 % vs. 3-month programme 0 % (*) Self-reported relapse to heroin use: 12-month programme 28.6 % vs. 3-month programme 53.0 % (*)			

Notes:  
(ns)  $p > 0.05$   
(\*)  $p \leq 0.05$   
(\*\*)  $p \leq 0.01$   
(\*\*\*)  $p \leq 0.001$

## Annex B

### European Therapeutic communities observational studies: features and outcomes

	Reference and country	Study design	Time to follow-up	Study population	Group studied <sup>(1)</sup>	Follow-up rate <sup>(2)</sup>	Outcomes				
							Retention <sup>(3)</sup>	Substance use <sup>(4)</sup>	Crime <sup>(5)</sup>	Employment <sup>(6)</sup>	Other <sup>(7)</sup>
1.	Lopez-Goni et al., 2011 (Spain, Navarra and Asturias)	Retrospective cohort study	12 months after leaving TC treatment	112 drug users retained in TC treatment for 12 months or more	Standard TC (22-month programme)		Treatment completion 69.7 %			Pre-vs. post treatment employment: 68.0 % vs. 74.0 % (ns)	
2.	Lopez-Goni et al., 2010 (Spain, Navarra and Asturias)	Retrospective cohort study	12 (±3) months after leaving TC treatment	112 drug users retained in TC treatment for 12 months or more	Standard TC (22-month programme)		Treatment completion: 69.7 %	Reduction in alcohol use as measured by ASI and RCI in 66.7 % of study population			Improved family relations as measured by ASI and RCI in 79 % of study population
3.	Lopez-Fernandez et al., 2011 (Spain)	Retrospective sequential cohort study	14, 36, 60 and 120 months after leaving TC treatment	93 alcohol and/or cocaine users retained in TC treatment for 3 months or more	TC (6-month programme)			Relapse: 51.1 % Pre-post-treatment: daily polydrug use: 33.3 % vs. 0 % Pre-post-treatment daily alcohol use: 73.8 % vs. 2.5 % Pre-post-treatment daily cocaine use: 58.6 % vs. 0 %	Pre-post-treatment: positive employment arrangement: 25.6 % vs. 50 %		Pre-post-treatment: suicidal ideation: 80.2 % vs. 38.4 %
4.	Davoli et al., 2007 (Italy)	Prospective cohort study	18 months following treatment start	10 454 heroin users commencing treatment	Standard TC, planned treatment duration not reported						Number of deaths during treatment: 0 (among 1 189 PY) Rate of deaths per 1000 PY during 30 days following TC: 21.6 [(adjusted HR = 23.0 (95 % CI: 7.63–69.31)]
5.	Salamina et al., 2010	Prospective cohort study	18 months following treatment start	5 457 heroin users commencing drug treatment (TC treatment, <i>n</i> = 575; MMT, <i>n</i> = 2 356; and abstinence-oriented therapies, <i>n</i> = 2 526)	Standard TC, planned treatment duration not reported		Median likelihood of retention: TC: 169 days vs. MMT: 300 days (***)				

(1) Type of TC; planned duration of the treatment programme is noted if specified in the original source.

(2) Proportion of original sample successfully followed up.

(3) Rate of retention in treatment for the planned treatment duration; time spent in treatment; treatment completion rate.

(4) Abstinence or relapse rates; time to first use following treatment.

(5) Recidivism or re-arrest rates; reincarceration; ASI score.

(6) Proportion employed.

(7) Homelessness; psychiatric disorders; quality of life.

	Reference and country	Study design	Time to follow-up	Study population	Group studied (†)	Follow-up rate (‡)	Outcomes				Other (°)
							Retention (§)	Substance use (§)	Crime (§)	Employment (§)	
6.	Fernandez-Montalvo et al., 2008 (Spain, Navarra)	Retrospective cohort study	6 months to 13 years post TC treatment	155 drug addicts commencing TC treatment	Standard TC (30-month programme) Comparison between treatment completers (n = 113) and treatment dropouts (n = 42)		Programme completion 51.2 %	Self-reported relapse to drug use: completers 32.7 % vs. dropouts 83.3 % (**); self-reported relapse to alcohol use: completers 13.0 % vs. dropouts 28.6 % (*)	Re-arrest/ reconviction rate: completers 5.3 % vs. dropouts 74.0 % (***)	Employment rate: completers 70.8 % vs. dropouts 26.2 % (***)	
7.	Fernandez-Hermida et al., 2002 (Spain, Asturias)	Retrospective cohort study	3 months to 96 months following TC treatment	Sample of 249 drug addicts commencing TC treatment	Standard TC (26-month programme) Comparison between TC completers (n = 194) and dropouts (n = 55)			Self-reported drug use: pre-treatment 100 % vs. post-treatment 22.1 % (***) Self-reported alcohol use: pre-treatment 20.8 % vs. post-treatment 10.0 % (***)	Re-arrest: pre-treatment 65.4 % vs. 8.0 % (***) Incarceration: pre-treatment 26.9 % vs. post-treatment 6.4 % (***)	Pre-treatment 11.9 % vs. post-treatment 63.9 % (***)	
8.	Quercioli et al., 2007 (Italy, Piedmont)	Retrospective cohort study	96 months following TC treatment entry	2 564 heroin addicts commencing TC treatment	Standard TC	45.0 %		Self-reported relapse: 41.0 %			
9.	Quercioli et al., 2006 (Italy, Piedmont)	Retrospective cohort study	96 months after leaving TC treatment	2 564 heroin users treated in TC	Standard TC	45.0 %		Reduced substance use problem severity as measured by ASI (*)			
10.	Berg et al., 2003 (Norway, Mysen)	Retrospective cohort study	36 months following TC treatment entry	130 drug addicts commencing TC treatment	Standard TC (18-month programme)	82.0 %	Mean time in TC treatment: 8.6 months	Relapse: 23.8 %		Employment/ school attendance: 38.5 %	Mortality: 6.9 %
11.	Keen et al., 2001 (United Kingdom, Sheffield)	Retrospective cohort study	13 months following TC treatment entry	138 heroin addicts commencing TC treatment	Standard TC (including on-site detox, if necessary) 12-month programme	81.2 %	Mean length of stay: 80.2 days. 25 % stayed ≥ 90 days				
12.	Fredersdorf, 2000 (Germany)	Retrospective cohort study	12–60 months following TC treatment entry	152 former residents of Synanon	Traditional TC	34.5 %		Abstinence rate: 56.9 %		Employment: 49.1 %	Stable relationship: 70.6 %; satisfied with relationship: 56.1 %; no contact with addicted persons: 63.5 %; self-regarded as 'socially integrated': 56.1 %

	Reference and country	Study design	Time to follow-up	Study population	Group studied (†)	Follow-up rate (‡)	Outcomes				Other (⁷)
							Retention (⁴)	Substance use (⁴)	Crime (⁵)	Employment (⁶)	
13.	Van de Velde et al., 1998 (Belgium)	Prospective cohort study	8, 18, 30 and 48 months following TC treatment entry	100 drug and alcohol users retained in TC treatment for 5 months or more	Standard TC (12-month programme)			Self-reported heroin use: treatment entry 23.0 % vs 8-month follow-up 6.0 % vs. 18-month follow-up 2.0 % vs. 30-month follow-up 5.0 % vs. 48-month follow-up 5.0 % Self-reported alcohol use: treatment entry 65.0 % vs 8-month follow-up 5.0 % vs. 18-month follow-up 3.0 % vs. 30-month follow-up 3.0 % vs. 48-month follow-up 8.0 %	Self-reported legal problems: treatment entry 33.0 % vs. 8-month follow-up 6.0 % vs. 18-month follow-up 5.0 % vs. 30-month follow-up 8.0 % vs. 48-month follow-up 9.0 %		Psychological problems: treatment entry 88.0 % vs. 8-month follow-up 72.0 % vs. 18-month follow-up 52.0 % vs. 30-month follow-up 47.0 % vs. 48-month follow-up 46.0 % 'Poor' physical health: entry 56.0 % vs. 8-month follow-up 23.0 % vs. 18-month follow-up 25.0 % vs. 30-month follow-up 29.0 % vs. 48-month follow-up 23.0 %
14.	Ravndal and Vaglum, 1998 (Norway, Mysen)	Prospective cohort study	60 months following TC treatment entry	200 drug users commencing TC treatment	Standard TC (18-month programme)	70.0 %	12-month retention in treatment: 30.0 %; completion of planned treatment programme rate: 20.0 %	Self-reported abstinence (or 'light drug use') in past year: 20.0 %; self-reported moderate drug use in past year: 25.0 %; self-reported heavy use in past year 56.0 %			Mortality rate: 12.4 %
15.	Ravndal and Vaglum, 1992 (Norway, Mysen)	Prospective cohort study	18 and 48 months following TC treatment entry	200 drug users commencing TC treatment	Standard TC (18-month programme) Comparison of HIV-positive and HIV-negative individuals	79.0 %					Mortality: HIV positive 10.3 % vs. HIV-negative 10.0 %
16.	Kooyman, 1992 (Netherlands, the Hague)	Prospective cohort study	49 (±12) months after leaving TC treatment	227 drug and alcohol users treated in TC	Standard TC (22 month programme)	75.8 %	1-year treatment retention rate: 28.2 % Mean length of TC treatment episode: early drop-out (< 15 days): 16.7 % TC graduates: 21.0 %	Self-reported abstinence: 32.0 %		Employment/school attendance: 58.5 %	Suicide attempts: pre-treatment 41.7 % vs. post-treatment 15.3 % (***)
17.	Uchtenhagen and Zimmer-Höfler, 1987 (Switzerland)	Prospective cohort study	24 months following TC treatment entry	248 opiate users commencing TC treatment	Standard TC (n = 79)	90.0 %			Recidivism: 49.4 %		

	Reference and country	Study design	Time to follow-up	Study population	Group studied <sup>(1)</sup>	Follow-up rate <sup>(2)</sup>	Outcomes				
							Retention <sup>(3)</sup>	Substance use <sup>(4)</sup>	Crime <sup>(5)</sup>	Employment <sup>(6)</sup>	Other <sup>(7)</sup>
18.	Wilson and Mandelbrote, 1985 (United Kingdom, Oxford)	Retrospective cohort study	10 years after leaving TC treatment	61 drug users treated in TC	Standard TC (24-month programme)	98.4 %			Reconviction: 57.0 %		Mortality: 10.0 %
19.	Wilson and Mandelbrote, 1978a (United Kingdom, Oxford)	Retrospective cohort study	24 months after leaving TC treatment	62 drug users treated in TC	Standard TC (24-month programme)	98.4 %			Reconviction: long TC stay pre-treatment 60.0 % vs. post-treatment 10.0 % (*) Reconviction: medium TC stay pre-treatment 70.0 % vs. post-treatment 45.0 % (*) Reconviction: short TC stay pre-treatment 57.0 % vs. post-treatment 57.0 %		
20.	Wilson and Mandelbrote, 1978b (United Kingdom, Oxford)	Retrospective cohort study	Up to 48 months after leaving TC treatment	61 drug users treated in TC	Standard TC (24-month programme)			Decrease in frequency of heroin injection among medium-stay group (*)			
21.	Ogborne and Melotte, 1977 (United Kingdom, London)	Retrospective cohort study	6 months after leaving TC treatment	100 opiate users treated in TC	Standard TC (10- to 12-month programme)	87.0 %	34.0 % left TC within 1 month; 32.0 % stayed > 6 months Completion rate: 9.0 %	Self-reported drug abstinence: 17.0 %; self-reported 'sporadic' drug use 14.0 %; self-reported 'regular' drug use (oral drug administration): 26.0 %; self-reported drug injecting: 44.0 %			

Note:  
(ns)  $p > 0.05$   
(\*)  $p \leq 0.05$   
(\*\*)  $p \leq 0.01$   
(\*\*\*)  $p \leq 0.001$



**Annex C****Controlled studies excluded from this review**

Full study reference	Country	Reason for exclusion
1. Sacks, J. Y., McKendrick, K., Hamilton, Z., Cleland, C. M., Pearson, F. S. and Banks, S. (2008), 'Treatment outcomes for female offenders: relationship to number of Axis 1 diagnoses', <i>Behavioral Sciences and the Law</i> 26, pp. 413–434.	USA	Analysis of outcome correlates
2. Skinner, D. C. (2005), 'A modified therapeutic community for homeless persons with co-occurring disorders of substance abuse and mental illness in a shelter: an outcome study', <i>Substance Use and Misuse</i> 40, pp. 483–497.	USA	Not a controlled study design
3. Sacks, J. Y., McKendrick, K., Pearson, F. S., Banks, S. and Harle, M. (2004b), 'Outcomes from a therapeutic community for homeless addicted mothers and their children', <i>Administration and Policy in Mental Health</i> 31, pp. 313–338.	USA	Secondary analyses of previously published data (De Leon et al., 2000)
4. Condelli, W. S., Koch, M. A. and Fletcher, B. (2000), 'Treatment refusal/attrition among adults randomly assigned to programs at a drug treatment campus. The New Jersey substance abuse treatment campus, Seacaucus, NJ', <i>Journal of Substance Abuse Treatment</i> 18, pp. 395–407.	USA	Only during-treatment outcomes reported
5. McGeary, K. A., French, M. T., Sacks, S., McKendrick, K. and De Leon, G. (2000), 'Service use and cost by mentally ill chemical abusers: differences by retention in a therapeutic community', <i>Journal of Substance Abuse</i> 11, pp. 265–279.	USA	Analysis of outcome correlates
6. Messina, N., Wish, E. and Nemes, S. (2000), 'Predictors of treatment outcomes in men and women admitted to a therapeutic community', <i>American Journal of Drug and Alcohol Abuse</i> 26, pp. 207–227.	USA	Secondary analyses of previously published data (Nemes et al., 1999)
7. Messina, N. P., Wish, E. D. and Nemes, S. (1999), 'Therapeutic community treatment for substance abusers with antisocial personality disorder', <i>Journal of Substance Abuse Treatment</i> 17, pp. 121–128.	USA	Secondary analyses of previously published data (Nemes et al., 1999)
8. Moos, R. H., Moos, B. S. and Andrassy, J. M. (1999), 'Outcomes of four treatment approaches in community residential programs for patients with substance use disorders', <i>Psychiatric Services</i> 50, pp. 1577–1583.	USA	Not a controlled study design
9. Toumbourou, J. W., Hamilton, M. and Fallon, B. (1998), 'Treatment level progress and time spent in treatment in the prediction of outcomes following drug-free therapeutic community treatment', <i>Addiction</i> 93, pp. 1051–1064.	USA	Not a controlled study design
10. Liberty, H. J., Johnson, B. D., Jainchill, N., Ryder, J., Messina, M., Reynolds, S. and Hossain, M. (1998), 'Dynamic recovery: comparative study of therapeutic communities in homeless shelters for men', <i>Journal of Substance Abuse Treatment</i> 15, pp. 401–423.	USA	Not a controlled study design
11. Graham, W. F. and Wexler, H. K. (1997), 'The Amity therapeutic community program at Donovan prison: program description and approach', in: De Leon, G. (ed.), <i>Community as method. Therapeutic communities for special populations and special settings</i> , Praeger, Westport, CT, pp. 69–86.	USA	Not a controlled study design
12. Knight, K., Simpson, D. D., Chatham, L. R. and Camacho, L. M. (1997), 'An assessment of prison-based drug treatment: Texas' in-prison therapeutic community program', <i>Journal of Offender Rehabilitation</i> 24, pp. 75–100.	USA	Not a controlled study design
13. McCusker, J., Bigelow, C., Vickers-Lahti, M., Spotts, D., Garfield, F. and Frost, R. (1997b), 'Planned duration of residential drug abuse treatment: efficacy versus effectiveness', <i>Addiction</i> 92, pp. 1467–1478.	USA	Secondary analyses of previously published data (McCusker et al., 1995)
14. Martin, S. S., Butzin, C. A. and Inciardi, J. (1995), 'Assessment of a multistage therapeutic community for drug-involved offenders', <i>Journal of Psychoactive Drugs</i> 27, pp. 109–116.	USA	Secondary analyses of previously published data (Lockwood et al., 1997)
15. Rice, M. E., Harris, G. T. and Cormier, C. A. (1992), 'An evaluation of a maximum security therapeutic community for psychopaths and other mentally disordered offenders', <i>Law and Human Behaviour</i> 16, pp. 399–412.	USA	Not a controlled study design
16. Charuvastra, V. C., Rehmar, R., Paredes, A. and McBride, M. (1989), 'Drug-free therapeutic community — a 10 year follow-up', <i>Addictive Behaviors</i> 14, pp. 343–345.	USA	Not a controlled study design
17. Barr, H. (1986), 'Outcomes in drug abuse treatment in two modalities', in: De Leon, G. and Zeigenfuss, J. T. (eds.), <i>Therapeutic communities for addictions</i> , Charles C. Thomas Publications, Springfield, IL, pp. 97–108.	USA	Not a controlled study design

## Annex D

### Overview of prison therapeutic community papers reporting controlled research

Reference	Comparison condition	Time to follow-up (months)	Outcome measures					
			Substance use reduction or abstinence	Relapse or time to relapse	Reduction in criminal activity or reoffending	Re-arrest or reincarceration	Employment	Health
Sacks et al. (2012)	TAU	12				+		
Zhang et al. (2011)	No treatment (standard work release)	12				=		
		60				=		
Messina et al. (2010)	Other TC	6	=			=		
		12	=			=		
Welsh (2007)	TAU	24	=			+	+	
Sullivan et al. (2007)	TAU	12	+ Illicit drugs + Alcohol	+				
Sacks et al. (2004)	TAU	12				+		
Morral et al. (2004)	No treatment (standard work release)	12	+		=			+
Inciardi et al. (2004)	No treatment (standard work release)	42	+		+			
		60	+		+			
Martin et al. (1999)	Other TC	18	+			+		
Lockwood et al. (1997)	Other TC	6	+			+		
Nielsen et al. (1996)	No treatment (standard work release)	6		+	+			
		18		+	+			
Guydish et al. (1998, 1999)	Other TC	12						+
		18						+
		6						+
Prendergast et al. (2003, 2004)	No treatment (on waiting list)	12		+		+		
		60	=			+	=	=
Wexler et al. (1999)	No treatment (on waiting list)	12				+		
		24				+		
Hartman et al. (1997)	No treatment (standard work release)	5	+			+		

Note:

+ statistically significant difference in favour of study treatment

= no difference in outcome between treatment conditions.

**Annex E****Overview of community therapeutic community papers reporting controlled research**

Reference	Comparison condition	Time to follow-up (months)	Outcome measures					
			Substance use reduction or abstinence	Relapse or time to relapse	Reduction in criminal activity or reoffending	Re-arrest or reincarceration	Employment	Health
Greenwood et al. (2001)	Other TC	6	+					
		12	=					
		18	=					
De Leon et al. (2000)	TAU	12	+ Illicit drugs + Alcohol		=		+	=
		24	+ Illicit drugs + Alcohol		+		+	+
Nemes et al. (1999)	Other TC	18	+			+	+	
French et al. (1999)	TAU	24	=		+		=	+
Nuttbrock et al. (1998)	No treatment (community residency)	12	+					=
McCusker et al. (1997a, 1995, 1996)	Other TC	3		=	=		+	
		3–6		=				
		6		+				
Bale et al. (1984)	TAU (five-day detoxification)	24	+ Heroin + Other illicit drugs – Alcohol			+	+	
Coombs (1981)	Other TC	12	+	+				
Bale et al. (1980)	TAU (MMT; detoxification)	12	+			+	+	
Guydish et al. (1998, 1999)	Other TC	12						+
		18						+
		6						+

## Note

+ statistically significant difference in favour of study treatment

– statistically significant difference in favour of comparison condition

= no difference in outcome between treatment conditions.

## Annex F

### Observational studies excluded from this review

Full study reference	Country	Reason for exclusion
1. Soye, V., De Leon, G., Broekaert, E. and Rosseel, Y. (2006), 'The impact of a social network intervention on retention in Belgian therapeutic communities: a quasi-experimental study', <i>Addiction</i> 101, pp. 1027–1034.	Belgium	Analysis of outcome correlates
2. Ravndal, E. and Vaglum, P. (1994), 'Treatment of female addicts: the importance of relationships to parents, partners and peer for the outcome', <i>International Journal of the Addictions</i> 29, pp. 115–125.	Norway	Secondary analyses of previously published data
3. Ravndal, E. and Vaglum, P. (1994), 'Self-reported depression as a predictor of dropout in a hierarchical therapeutic community', <i>Journal of Substance Abuse Treatment</i> 11, pp. 471–479.	Norway	Only during-treatment outcomes reported
4. Ravndal, E. and Vaglum, P. (1994), 'Why do drug abusers leave the therapeutic community? Problems with attachment and identification in a hierarchical therapeutic community', <i>Nordic Journal of Psychiatry</i> 33, pp. 4–55.	Norway	Only during-treatment outcomes reported
5. Ravndal, E. and Vaglum, P. (1992), 'Different intake procedures: the influence on treatment start and treatment response. A quasi-experimental study', <i>Journal of Substance Abuse Treatment</i> 9, pp. 53–58.	Norway	Only during-treatment outcomes reported
6. Ravndal, E. and Vaglum, P. (1991), 'Psychopathology and substance abuse as predictors of program completion in a therapeutic community for drug abusers: a prospective study', <i>Acta Psychiatrica Scandinavica</i> 83, pp. 217–222.	Norway	Only during-treatment outcomes reported
7. Ravndal, E. and Vaglum, P. (1991), 'Changes in antisocial aggressiveness during treatment in a hierarchical therapeutic community. A prospective study of personality changes', <i>Acta Psychiatrica Scandinavica</i> 84, pp. 524–530.	Norway	Only during-treatment outcomes reported

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